DOCUMENT RESUME

ED 222 820 CG 016 288

AUTHOR Gerber, Sterling K.
TITLE Responsive Therapy.
PUB DATE Apr 82
NOTE 175p.; Paper presented at the Annual Meeting of the Western Psychological Association (62nd, Sacramento, CA, April 7-11, 1982).
PUB TYPE Reports - Descriptive (141) -- Speeches/Conference Papers (150)

EDRS PRICE MF01/PC07 Plus Postage.
DESCRIPTORS *Counseling Techniques; *Counseling Theories; *Counselor Client Relationship; Counselors; *Intervention; Models; Program Descriptions; Therapeutic Environment; Therapists; *Therapy
IDENTIFIERS *Responsive Therapy

ABSTRACT

This paper is an attempt to develop a therapeutic stance, responsive therapy, for counselors that abandons the effort to select the one "true" therapeutic emphasis, and is based on the assumption that all therapeutic emphases are "true." A description of counselor behavior ensues which enhances a therapeutic atmosphere, moves clients systematically toward an objective view of her/his circumstances, and creates a position from which various intervention strategies may be used contextually intact in response to the reality clients face. The author views responsive therapy as a viable position for therapists who cannot be comfortable with either a single approach or eclecticism. Chapter 1 is an introduction which attempts to identify a common thread in all therapies, e.g., the introductory interview, relaxation training, and history taking. Chapter 2 examines the therapeutic environment, e.g., the external physical environment and the internal environment of the counselor and client. Chapter 3 discusses tracking skills, those strategies employed by the counselor to move the client through the therapeutic process. Chapters 4 and 5 address general and specific enhancing skills. Chapter 6 explains the experiential, philosophical, and theoretical bases that undergird responsive therpay. The theoretical model for responsive therapy is described in detail. A reference list is included. (Author/PAS)

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RESPONSIVE THERAPY

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Paper presented at the Annual Meeting of the Western Psychological Association, Sacramento, CA, April 8-11, 1982.

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Foreword

In its infancy, the counseling profession was concerned with ascertaining client abilities and matching them to occupational demands. The counselor, who was knowledgeable in assessment methods and aware of work requirements, was in a key position to diagnose and prescribe.

The same process was readily generalized to school guidance program needs and psychological treatment programs. Clients, who were deficient in some regard, sought consultation with counselors, who were wise and sensitive and could direct the clients toward proper adjustment.

As a natural parallel, the testing movement fit very well into the assessment-diagnosis-prescription model of therapy.

This model formed the basic structure for E.G. Williamson's Directive Therapy, popularized in his writings in the 1940's and into the 1960's (1939, 1950, 1958, 1965, Williamson and Bordin, 1941).

As is typical to the dymanics of strong advocacy, where one position is countered by an opposing one, approaches having differing philosophical bases and contrasting with Williamson's approach were developed. The most prominent oppositional system was labeled Non-Directive Therapy by its principal advocate, Carl Rogers (1942). His system was based on the premise that people possess the capability of solving their own problems if provided an atmosphere conducive to objective self-awareness and positive support--conditions natural to people but distorted or perverted by societal practices. Unconditional positive regard, warmth, and empathy on the part of the counselor toward the client provided a climate which was facilitative of self-directed, progressive behavior on the part of clients (Rogers, 1961).

With such seemingly dichotomous systems competing for the allegiance of neophyte therapists, it was predictable that intermediate approaches would be created. Among these was truly a middle ground approach advanced by Frederick Thorne called Eclectic Therapy (1950,1961).

Eclecticism is the process of selecting what is considered best from different systems or sources and favoring no particular belief or practice. While this notion appealed to many counselors as the only defensible system, it had two perceived weaknesses: (1) it required diagnosis as a prior accomplishment to selection of the best approach, which was contrary to the non-directive philosophy, and (2) it advocated the use of techniques disembedded from their philosophical and theoretical contexts.

During the 1950's, students of counseling were offered, in essence, three choices: Directive Therapy, Non-Directive Therapy, or Eclectic Therapy. For those who viewed eclecticism as a perversion of methods and, hence, misdirected and probably counterproductive, there were only two choices. As a result, students who could comfortably become disciples of Williamson or Rogers did so, and most others called themselves eclectic for want of a better label.

This same set of dynamics occurred in the larger context of psychology with the establishment of ground rules in the "schools" era when behaviorism, functionalism, structuralism, and gestalt camps were battling for prominence (Woodworth and Sheehan, 1964). This was later supplanted by the Stimulus-response Associationism versus the Cognitive-gestalt era (Bigge, 1976).

Without tracing the philosophical or theoretical genealogy of each, the either-or, to diagnose or not to diagnose kinds of dynamics have

resulted in a plethora of counseling approaches, each with its proponent and disciples and each claiming to be a little closer than all the others to "Truth." Some examples of current therapies are Neo-Freudian (Ford and Urban, 1963), Ellis and Rational-Emotive Therapy (1969), Berne and Transactional Analysis (1961), Perls and Gestalt (1969), Wolpe and Behavioral Therapy (1973), Glasser and Reality Therapy (1965), Lowen and Bioenergetics (1975), Biofeedback (Birk, 1973), and Humanistic Counseling (Sutich and Vich, 1969).

There remains the temptation of eclecticism as a means of resolving the "duty" to choose an approach, but it still suffers from the fractionating and invalidating problem resulting when methods are administered out of context.

Several studies imply that such position-making and gathering of disciples approximates being so enamored with their chosen tree, that the proponents and disciples alike are unable, indeed, to see the forest before them. Fiedler (1950) drew the conclusion that accomplished therapists across identity lines were more similar than were new and more experienced therapists within the same therapeutic emphasis. Combs and Soper (1968) asserted that there are critical perceptual skills which are common to proficient therapists without regard to theoretical identity; these skills included the tendency to perceive from an internal rather than external frame of reference and the preference to organize around people rather than things. Studies supporting the notion that some clients because of their unique personalities are helped more readily if matched to counselors with similar styles (Berenson and Carkhuff, 1967) and inferences that well-known therapists attract clients who are more apt to "fit" their preferred approach suggest a differential worth of

therapeutic approaches.

Suppose that one were to abandon the effort to select from the many therapeutic emphases the one which is "True" and, instead, were to assume that they are all "True." Suppose further that s/he entertains the hypothesis that, at least in the initial stages of therapy, being therapeutic is not theory specific. Then s/he could adopt a broader view of the forest and could entertain an integrative stance which (1) does not suffer the contextual difficulties of eclecticism, (2) allows for the ability and responsibility of the client to be an active part of his/her therapy, (3) validates the importance of a properly therapeutic atmosphere, and (4) does not excuse the therapist either from knowing what is happening or from initiating interventions which have a high probability of success.

This book is an attempt to develop such a stance, to describe counselor behavior which enhances a therapeutic atmosphere and moves the client systematically toward an objective view of her/his circumstances, and to create a position from which various intervention strategies may be used contextually intact in response to the reality the client faces.

The content is not particularly new, but the organization and underlying philosophy is both unique and timely.

Chapter I INTRODUCTION

"What kind of a therapist are you?"

"A good one!"

"No! I mean, are you Adlerian, Rogerian, Skinnerian? Do you emphasize Gestalt, Rational-Emotive, Transactional Analysis, Bioenergetics, or what?"

Such a dialogue is common among sophisticated and not so sophisticated counselors, therapists, and mental health specialists. It may even occur between a prospective client and therapist. There is an assumption in such an interaction that one cannot be therapeutic without identifying with a prominent movement. But everyone knows that ministers, bartenders, hairdressers, friends, and even strangers can be therapeutic.

What does a trained therapist do which is different from what the neighbor does? What does a Freudian therapist do that differs from a Rogerian therapist?

Part of the answer is, "Nothing." The dynamics of being therapeutic are the same across many clients and many helpers. Presumably a trained therapist is more sensitive and more efficient in managing those dynamics than is a neighbor or bartender. Presumably also, therapists with differing labels employ selected techniques in contrasting ways.

Three levels of therapy seem to be implied in the above statements. The first is where non-professionals perform in therapeutic ways, perhaps accidentally or through common sense.

The second level assumes that all therapists share similar techniques which promote client progress and prepare the way for more specialized techniques.

The third level is that of the therapist who manifests skills in accordance with a specialized, theoretical approach typically referred to by titles such as Gestalt, or Behavior Modification, etc.

This book is focused on the middle level. It provides (1) some evidence for the existence of such a level, (2) explicit descriptions of skills and approaches common to all "good" therapists, (3) integration of common skills to specialized approaches, and (4) a philosophical framework.

A Common Thread in Therapies

Studies such as Fiedler's (1950), those reported by Berenson and Carkhuff (1967), and Combs and Soper (1968) provide support for the notion of similarities across approaches by therapists who are effective. Descriptions by therapists of their unique approaches occasionally describe or imply preparatory skills. For example, in the study of some materials on reciprocal inhibition (Wolpe 1978, Wolpe 1973, Yates 1970), some ideas appeared to be incongruent with stereotypical notions of a behavioral approach. Contrary to the presumed "formula" nature of elaborating a fear hierarchy and systematically proceeding through visualizations, some statements relating to the individuality of and variations among clients were made. Procedures such as the introductory interview, history taking, relaxation training, and hierarchy establishment were described dynamically as similar in some respects to other kinds of therapy. At one point when suggesting studies comparing nonbehavioristic therapies with behavioral counseling, Wolpe wrote, "Any comparative study, to be satisfactory, would have to allow for the inadvertant therapeutic effects that all psychotherapies share...." (1978, p. 443).

In addition, then, to potential differential effects of contrasting theories, there apparently are common or similar elements which have therapeutic effects across theoretical lines. Some obvious similarities would include faith in the therapist, desire to "get better," investment of money and effort in the process, and prediction of positive change. These are conditions that a client brings to any counseling experience which tend to support its success.

Might it be possible that a portion of the successful actual counseling process is common to all therapies and, hence, atheoretical? Perhaps the initial interactions, during which time (1) a relationship is established, (2) problems are identified and/or elaborated, and (3) objectives become established, are similar--whether or not prior testing has been done, whether or not a diagnosis has been made, and whether or not the presenting problem is at all related to the real therapeutic objective.

Were this true, it would be possible to begin all therapy in very much the same way and wait until the real problem is identified, the style of the client ascertained, and the options for treatment known before selecting a method. Selection of treatment at this juncture would allow authentic application of any therapy model within its proper philosophical and theoretical context.

If some problems are served better by certain approaches, and if some clients respond selectively better to certain strategies, then a practice of selecting the approach or strategy after the problem is identified and the client preference determined is much more efficient than trying to fit all clients and all problems into a counselor's preferred mode. It is also better than forcing clients to experientially

shop for a therapist of proper compatibility; especially it is preferable to applying selected techniques out of context and perhaps with conflicting theoretical dynamics.

Premises

This book is based on the above reasoning and the following premises:

(1) All models of therapy are effective when used appropriately.

(2) There are similarities across models in the early stages of therapy.

(3) Models which begin with diagnosis almost invariably refine, alter, or replace the original diagnosis.

(4) Models that begin without diagnosis establish or evolve one in the process of therapy, whether or not it is ever explicated.

A statement of philosophy which supports and integrates this entire approach or position is elaborated in the final chapter.

Analyzing Therapy

Therapy can be described from several perspectives. The general sequence of experience is one. For example, the four stages in therapy are (1) ventilation, (2) clarification, (3) alteration, and (4) adaptation. Before accomplishing any change, a client has to deal with a build-up of emotions. The process of talking, swearing, crying about--of expressing those emotions is called ventilation. In and of itself, ventilation usually is therapeutic. Most people feel better after having talked over or cried out their problem, whether to a relative, minister, bartender, or therapist.

Just ventilating does not solve the problem, and if nothing more is done, the emotions will build up again and a cycle of ventilation--build-up--ventilation is created. The second phase in therapy usually requires a skilled helper. This is the clarification phase. During this portion of therapy, the helper causes the client to examine his/her unique, personal world through the process of communicating it to the helper. Often, the client sees and describes her/himself in new and insightful ways. This too is therapeutic, and in many models of counseling is essentially the end of therapy. If the client is seen as competent to solve problems but confused, then clarification is all that is needed.

In many circumstances, even though understanding his/her problem, the client needs to be taught appropriate methods to solve the problem or alter the circumstances. This is the alteration phase. It is here that very specific methods with unique strengths can and should be selectively taught to the client in accord with her/his ability to understand and with the probability of accepting and applying the solution. Bibliotherapy, typically, would not be the prescribed method for a non-reader to learn about social graces. Methods for altering emotional responsiveness are not very efficient when applied to intellectual conflict or to self-defeating behavior.

Adaptation refers to getting used to the changes. It is the "refreezing" phase of the Lewinian system of change which requires an unfreezing of old behavior, a change, and a refreezing of the new pattern (Bennis, et.al., 1973).

A second perspective for describing therapy is that of techniques used in its various stages. The acronym, SITE, refers to an integrated set of skills used primarily in the clarification phase of therapy. It stands for sequential initiating, tracking, and enhancing skills.

The SITE system categorizes and organizes several therapeutic communication skills according to their sequence of occurrence in therapy. The same organization provides a reasonable teaching—learning sequence for the student of counseling.

Initiating skills are those which are used to structure the beginning of the therapy process. They help clients to perform more efficiently in their own behalf and support the early establishment of the counseling relationship.

Tracking skills enable the counselor to verify her/his understanding of the client's circumstances and condition. They also enhance a more complete awareness on the part of the client of his/her own condition.

Enhancing skills are employed selectively to improve some aspect of the therapeutic interaction. Some may be used with all clients, others may be necessary and prominent with some clients and entirely absent with others.

Collectively, the SITE system is a means for moving efficiently toward the core of a client's concerns, homing in on the bullseye of the target, or moving through a funnel from the surface and generalized dynamics at the funnel's lip to the specific and focused action at the spout.

Although the events in therapy vary greatly from client to client, there tends to be a general pattern or sequence. The skills which assist,

direct, or establish this sequence are:

I. Initiating Skills
   - A. Indirect Lead
   - B. Paraphrase of Content
   - C. Summary of Content

II. Tracking Skills
   - A. Paraphrase of Message
     1. Reflection of Feelings
     2. Description of Situation
     3. Formalization of Non-Verbal Cues
   - B. Summary of Messages

III. Enhancing Skills - General
   - A. Perception Checking
   - B. Proper Use of Silence
   - C. Physical Contact, Touch
   - D. Pacing
   - E. Minimizing Interrogation
   - F. Managing the Process

Ultimately, psychotherapy is a very personal event which probably defies accurate description. Therapists or helpers can only describe, relate, or organize those things which seem consistently to promote or enhance change in the client.

This book is an attempt to integrate the sequence of experience and that of procedures in a philosophically consistent manner. Chapter II treats initial interview dynamics and skills. Chapter III will deal with clarification dynamics and techniques. General enhancing skills which support therapeutic movement throughout the duration of therapy

or at critical times within the process are the focus of Chapter IV. Chapter V shows the importance of a number of therapeutic methods and how each may be selected and applied in an internally consistent manner and with increased probability for success. Chapter VI provides a theory base, an integrative view of psychological reality which supports the possibility of a truly responsive therapy.

Summary

There seems to be confusion and competition among various proponents of therapeutic methods as to which is truly effective. This is further confounded by untrained, nonprofessional people demonstrating therapeutic results in some relationships.

Studies and writings which emphasized the common elements or similarities in various kinds of therapy offer the possibility that contrasting theories are merely part of a larger whole, rather than distinct entities by themselves.

Trying to fit contrasting theories into an inclusive model requires looking for similarities and/or a framework within which all make sense.

Therapy can be described by reference to experience and technique. One sequence of experience includes ventilation, clarification, alteration, and adaptation. One sequence of techniques is typified by some sequential initiating, tracking, and enhancing skills (SITE).

The experience and technique descriptions will provide the framework supported by an integrative philosophy which together will permit a truly responsive model of therapy.

Chapter II INITIATING THE COUNSELING PROCESS

Successful therapy can occur in a variety of places and under a wide range of circumstances. There are some guidelines, however, that provide increased probability of success when followed.

External Environment

The basic general principle concerning the physical environment for counseling is that nothing in the environment draws attention away from the therapeutic interaction. This means that:

1. temperature should be moderate and comfortable.
2. furniture be soft but not too soft, impressive but not ostentatious.
3. noise be absent, or at least unintelligible.
4. lighting be soft but not too low.
5. interruptions be minimized; phone calls intercepted, entering of space by others prevented.
6. visual distractions be reduced or eliminated.
7. furnishings be arranged so as to reduce or remove differences in status or other barriers between therapist and client.

Internal Environment: Counselor

There is a parallel between external and internal environments in two ways: (1) therapy can be successful even with a competitive environment; and (2) it tends to go much better when distractions are limited or absent. The client deserves the full attention of the therapist; however, therapists are human and subject to all of the problems which that entails. Illness, dissonant relationships, overextension of energy and means, professional considerations, and even occasional aversions to

what they are doing and with whom, impinge on counselors as readily as on anyone else. Rules for the therapist in this regard include:

1. Resolve personal problems outside of the session.
2. Level with him/herself and with the client relative to interpersonal factors affecting both of them.
3. Monitor self so that the client can be postponed, rescheduled, or referred at any time when the therapist is unable to perform effectively and professionally due to competing interests.

Internal Environment: Client

Almost by definition, the internal state of the client is disturbed, confused, and self-defeating. One critical reason for establishing a therapeutic relationship is the creation of an internal environment facilitative of productive change. Creating such a relationship is one of the early and high priority objectives in therapy. The skills employed by the counselor in the initial stages of the interview are critical in setting up a supportive and yet work-promoting relationship. Given the probability of an internal client state which prohibits self-awareness or the ability to work on his/her problems, there is a necessity to alter that internal state. Studies of tension demonstrate that too much anxiety prevents effective learning, and too little tension also produces poor learning (Speilberger, 1966). Likewise, too high an emotional state or near absence of affect does not provide for effective therapy.

Ventilation, the talking out, swearing, crying-out behavior of a highly emotional client is the natural process of reducing tension to a tolerable level. This process should be encouraged and allowed to run its course without much interruption. Frequently several sessions are

necessary to accomplish adequate ventilation. Care needs to be exercised in the transition from ventilation to problem processing and resolution. The improvement in feelings which accompanies ventilation gives the illusion of being "cured," resulting in client drop-out.

Absence of affect indicates the presence of denial and over-control. Proceeding with initiating and tracking skills is the appropriate strategy; however, progress tends to be slow with considerable repetition of content until the emotional level approximates normal.

Approach

The proper and effective use of certain skills at the outset is critical to the establishment of proper structure and a therapeutic relationship.

The counselor's objective is to communicate to the client the messages:

1. "You talk; I understand."
2. "You set the direction; I track."
3. "You provide the material; I control and direct the process."

Any time spent in non-productive talk, "making the client comfortable," or engaging in conversation is not necessary, and in fact, is counterproductive. It tends to communicate light, social interaction which is predominantly role-directed and marked by inefficient communication.

Based on the realization that the client will look to the counselor to establish the ground rules and "tell him how to be a good client," the therapist should move quickly through the social amenities and directly into the initiating skills.

Initiating Skills

In order for therapy to be productive, the client must communicate his/her content, in his/her style, and in a sequence determined by him/her. The initiating skills called Indirect Leads, Paraphrase of Content, and Summary of Content are the tools for establishing control of the process and moving quickly into a working interaction.

Indirect Leads Any counselor statement which conveys, "Tell me about yourself, tell me more, or give me a specific example," is an indirect lead. The exact words and type of indirect lead will vary with therapist, client, and sequence of dynamics.

The "tell me about yourself" type of indirect lead usually occurs at the beginning of therapy immediately following the brief social amenities. Some examples are:

"Tell me about yourself."

"Share with me what's happening in your life."

"Give me some background -on you."

-on what's concerning you now."

-on what brought you to me."

"I need to get a feeling for who you are. Tell me some things about you."

"In order for counseling to work, you need to talk and I need to listen and understand. So talk about anything you would like to."

Often a client will request more structure by asking the therapist to be more specific; e.g., "What do you want me to talk about?" or "What do you want to know?

This represents a critical point in establishing the dynamics of the interaction. Inherent in the question is a structure where the

counselor asks questions and the client is in the position of control and can choose to give acceptable answers, pleasing answers, incomplete answers, misleading answers, or no answers at all. The therapist must struggle to ask questions which are pertinent to the client's "problem," which is a mystery until the client describes it, and then the therapist must somehow decipher what is truly going on from the answers selectively given by the client. If the counselor gives up control of the process at this time, the therapeutic interaction will probably deteriorate quickly into a "twenty questions" game or an interrogation.

Only by studiously avoiding closed questions, the type that can be answered "Yes," "No," or with a one or two word reply, can the therapist avoid the interrogation trap.

By way of digression, almost any type of interaction can be used to advantage by a seasoned therapist, even interrogation, strong confrontation, and insult. Most successful therapists most of the time will avoid such tactics until a working relationship has been established.

So what can the therapist do when the client asks, "What do you want to hear?" She/he has basically two choices of effective response. The first is to give initiative back to the client by saying something like:

"You decide."

"Whatever is happening with you."

"I'm not sure, so just begin with whatever comes to mind."

A second tactic is to give a multiple-choice lead; e.g., "Oh, I don't know. Maybe some background information like family history, where you're from, what you're doing now, relationships you have, concerns, frustrations,..." Such a lead requires the client to make a choice and to divulge more of self than through response to a closed question.

Chances are pretty good that the chosen topic will be important to the client and hence more useful to therapy than would a short reply to a closed question which would, at best, satisfy a curiosity of the counselor.

Remember that the major purpose of early indirect leads is to get the process started properly. If successful, the client will expose or give hints of her/his agenda, will establish a direction for the counselor to track, and will give process control to the therapist.

The "tell me about yourself" type of indirect lead is useful at the beginning of subsequent sessions, but usually takes on a slightly different quality; e.g.:

"Share with me where you're at now."

"What's happening today for you?"

"Fill me in on important feelings, thoughts, or happenings since last time."

"Bring me up to date."

Such leads have the effect of helping the counselor get into the proper frame of mind relative to the specific client, and more importantly, allowing the client to introduce new material or new perspectives. A very close follow-up on the previous session may prevent more important material from coming up and also denies the fact of therapeutic growth happening between sessions.

An indirect lead at the beginning of each session reaffirms the process dynamics of "You talk, I track," or "You work, I coach."

Occasionally during a session, the client will pause or stop, presumably having satisfactorily explained her/himself but leaving the therapist hanging. It is here that the furthering response of "tell me

more" is appropriate. Some examples are:

"Please expand on that a little."

"Give me a few more details."

"I'm not sure I understand. Tell me more."

The most powerful type of furthering response is, "Give me an example." It is common for clients to share conclusions in semi-knowledgable, often psychological terms. "I've got a depression," or "It's like I'm not really in control" are a couple of examples. This is similar to a person telling a physician, "I've got appendicitis." The physician would be foolish to initiate an appendectomy without checking the experiences or complaints which led the patient to his/her conclusion. Similarly the therapist, by asking for specific examples, can understand more clearly what is actually happening to the client and ascertain the client's meaning of "depression" or "not in control" or whatever. This allows the therapist to draw his/her own conclusions relative to the disruptive dynamics in the client's life.

Paraphrase of Content Another skill which is helpful in initiating therapy and bridging into the tracking phase is Paraphrase of Content. The early content may or may not be significant. Often it is just the vehicle for ventilation or establishment of relationship.

A Paraphrase of Content is a statement by the therapist of what the client just said. It is not exactly the same words, which would be simply parroting the client, but is usually the same content said more briefly with more precise, denotative words. It's the sort of thing you would say following the phrase, "What you're saying is..." or "What you're telling me is...." Beginners may use such phrases preceding

a paraphrase to remind them of what they're doing; however, a good paraphrase does not include them. Paraphrases of Content are voiced in a matter-of-fact, declaratory way; they do not end with an upward inflection or question hook. If stated as a question, they become closed questions answered by "Yes" or "No," thus stopping the flow and inviting a change to an interrogative interaction.

The effect of successful Paraphrase of Content is threefold; first, it helps to establish an atmosphere of acceptance, warmth, and positive regard. It says, "I care about what you are trying to tell me." Second, it supports the structure of interaction by encouraging the client to go further toward increased disclosure. Third, a good Paraphrase of Content moves the interaction from imprecise, connotative communication filled with excess and confusing meaning toward a more precise, denotative communication which is less subject to misunderstanding.

The effect of this and other counseling techniques is enhanced or inhibited by counselor non-verbal cues. Usually an alert, attentive countenance appropriate to attentive listening, combined with eye contact, and a facilitative posture establishes or reinforces the, "I care; you are important," messages which provide the atmosphere for a productive internal environment for the client.

Some examples of Paraphrase of Content are:

Client: "I don't know...sometimes I think I'm jinxed or something. Like this morning...my alarm clock didn't ring so I was late to work, and on the way I had a near accident, and my emotions were frazzled so when the boss mentioned I was late, I told him to 'stick it in his ear.' Some days it just doesn't pay to care."

Counselor: "You experienced some bad events today, beginning with a nonfunctioning clock, all of which seemed to you to be outside of your control."

Client: "My spouse does some of the dumbest things... like mouthing off and scolding me for little inconsequential things. I really dislike that kind of treatment. But on the other hand, there are times when I wouldn't want to be married to any other person.... I feel very fortunate to have the partnership and love...."

Counselor: "You find yourself both irritated and pleased by certain actions of your spouse."

Note should be taken that a good, useful Paraphrase of Content need not always be accurate or complete. It is merely the counselor's attempt to disclose her/his awareness of the client's response. A slightly incorrect paraphrase typically evokes an attempt on the part of the client to correct the misunderstanding, thus furthering the interaction.

Paraphrases of Content are most useful during the early stages of therapy as a follow-up to indirect leads. They will ordinarily give way to the more effective tracking techniques as soon as ventilation has been accomplished and the basic interactional process has been established.

Summary of Content By the limiting nature of communication, information comes from the client in a linear, one-at-a-time fashion. The reality experienced by the client is not so simple and orderly. This being the case, it is helpful to both partners in therapy, client and counselor, to occasionally review what has been discussed. It is a highly unusual experience for a client to explain his/her circumstances in an orderly, meaningful fashion. More often than not, client output is similar to the preadolescent child relating the sequence of a movie or television show with frequent corrections in the form of, "Oh! I forgot. Back before the train derailed...." Sometimes there will be several themes (problems, concerns) which are verbalized in a shot-gun

fashion, with alternation back and forth among those themes.

Summaries of content permit the counselor to periodically review out loud the major ideas in a sequence that makes sense to her/him. This provides for verification of content, allows both partners to look for patterns or recurring themes, and tends to pace the flow of information and analysis--picking up the pace when there are major gaps in the story, slowing it down when the informational output is too fast to assimilate.

An example of Summary of Content is:

Counselor: "Let's see now. You've talked about three areas--

1. your school years, which were sort of mixed up--with success in studying but not too much social success.

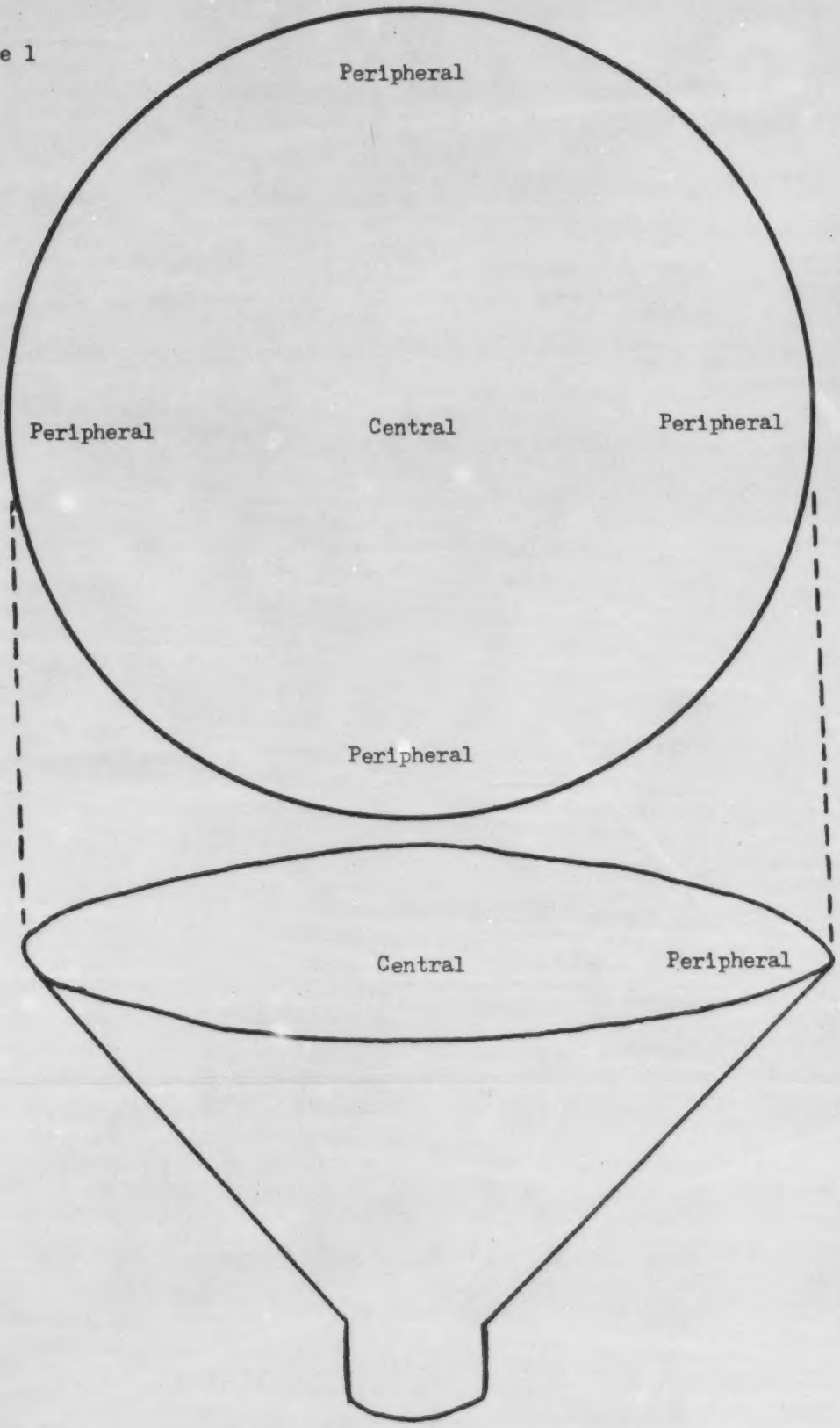
2. your employment pattern of doing well in jobs where you worked alone and could control your activities; but not so well when closely supervised, and

3. your marriage and the tendency to like, love, appreciate your spouse when away from home and seeming inability to tolerate 'interference' that comes when you're closely involved."

Funnel Analogy

The communication process in the initiating and tracking phases of counseling can be likened to a funnel (see figure 1). Content exists primarily in the plane crossing the lip or top portion of the funnel. Immediately below the content level are underlying messages and feelings. At or near the spout or bottom of the funnel is the point of greatest dynamics where messages, themes, and situational clues establish the problem or concern or self-defeating characteristic of the client's life and style which creates the need for therapy.

Figure 1


Peripheral
Peripheral
Central
Peripheral
Peripheral
Central
Peripheral

Initiating skills focus only upon the content plane or level. In addition to teaching the client how to operate in the process of counseling, they permit counselor exploration and understanding of relatively superficial (hence minimally threatening) but useful information concerning the client's circumstances. Much the same as with a funnel, where all material at the top flows down through the spout, all content is related to underlying messages and themes. It is not sufficient to work only with content because the more important dynamics are sometimes disguised or so embedded in the content as to be difficult to discern. Nor is it necessary to explore all possible content, for once some major messages and themes are known, more rapid and efficient progress can be made toward problem definition and resolution.

Presumably there is a variation in importance of content ranging from that which relates more closely or is central to the major problem dynamics, to that which is more peripheral. Clients will vary greatly on where they begin, some jumping right into central content, others being much more cautious or defensive and beginning with peripheral content. This can be visualized in the funnel analogy.

Indirect Leads permit the client to begin where s/he is most comfortable. Paraphrases and Summaries of Content encourage and facilitate movement toward central content.

Additional techniques are required to get below the content level. They will be described in Chapter III.

Summary

While therapy can happen under many conditions, some are more efficient or productive than others. A supportive external environment which does not draw attention away from therapy is helpful. Likewise, internal counselor and client environments can facilitate or impede progress. The counselor needs to monitor himself and also help the client through ventilation and/or other experiences to create the most productive internal environment.

The counseling interaction should be established early in therapy and controlled by the counselor. The most efficient interaction requires the client to produce and the counselor to understand. Skills for initiating this process are Indirect Leads, Paraphrase of Content, and Summary of Content.

Therapeutic communication is likened to a funnel, with content at the top, messages and themes in the middle, problem dynamics and personal style at the spout. The initiating skills of Indirect Leads, Paraphrase of Content, and Summary of Content serve to establish the proper interaction, allow the client to begin with content s/he is relatively comfortable with, and move systematically toward more central content.

Exercises: Chapter II

I. Indirect Leads

Basically, any lead which produces more than a "yes, no," or one word reply is an indirect lead; however, there are varying degrees of openness and also qualitative concerns. Do the following exercises, recognizing that you will not know all of the principles and, hence, will not perform perfectly.

A. You are a counselor who has just received a new client into your office. You have finished the brief social amenities and are ready to go to work. Write three different indirect leads for initiating the process.

1.

2.

3.

B. This is the beginning of the fourth session with your client. Write three indirect leads for getting this session under way.

1.

2.

3.

C. Label the following statements direct or indirect and analyze each regarding probable effectiveness.

1. Tell me about yourself.
2. Why did you do that?
3. Do you feel happy?
4. How do you feel now?
5. How much do you weigh?

6. What is that like for you?

7. Tell me about your fear.

8. Tell me more about that.

9. Did you go to the party last night?

10. I would like to hear you elaborate on that.

11. Please tell me why you are here.

12. How are you today?

II. Paraphrase of Content

A. Write a paraphrase of content for the following:

1. I'm about $400.00 in debt. My car insurance is being increased because of that accident. Tuition is overdue, and the bank has been trying to contact me about being overdrawn. I really hate to go to my father for help. He will bail me out, but it makes me feel like a failure.

2. During my trip to Mexico I met the neatest guy. We really hit it off well. Never have I felt so strongly for someone, nor given so freely and totally. I know I can't pursue the relationship because of all the problems involved. But how can I tell my fiance; and how can I accept him when, comparatively, he seems so dull and ordinary?

3. Just because they are getting a divorce is no reason for them to hassle me. It's almost like they are fighting each other through me. I love them both and don't want to take sides. How can such wonderful people be so totally childish?

4. What's the big deal about being 33 years old and not married? I know lots of unmarried women, and they seem perfectly happy, but the way people talk, you'd think I'm some kind of freak or lesbian or something!

5. I want to be an auto mechanic, but at every school I go to, I get teased so badly about being a woman that I end up quitting. Should I change my goal?

6. My sister smokes pot. She is only fifteen. I'm afraid that she's on the wrong path, but she retorts that her peers' approval is more important to her than mine.

B. Compare your paraphrases of content with the following examples and select the best for each example.

1. I'm about $400.00 in debt. My car insurance is being increased because of that accident. Tuition is overdue,

and the bank has been trying to contact me about being overdrawn. I really hate to go to my father for help. He will bail me out, but it makes me feel like a failure.

a. It's really not fair for insurance companies to increase your premium just because you had an accident.

b. It seems like problems come in bunches. You have a debt, more insurance to pay, a tuition bill, and no money in the bank.

c. You have several financial problems--a $400.00 debt, increase in insurance, tuition overdue, and bank account overdrawn. The only solution you can see is to have your father help, but doing so will cause you some bad feelings about yourself.

d. It's really bad to be dependent on your father. While he has enough money to bail you out, you'd really like to prove that you can handle things yourself.

2. During my trip to Mexico I met the neatest guy. We really hit it off well. Never have I felt so strongly for someone, nor given so freely and totally. I know I can't pursue the relationship because of all the problems involved, but how can I tell my fiance; and how can I accept him when, comparatively, he seems so dull and ordinary?

a. You fell in love with a guy in Mexico, but somehow you can't follow through on that relationship. You're left with a fiance to whom you've made some promises which will be hard to keep since you prefer the other man.

b. You let yourself get hooked on a vacation romance and now you're paying the price.

c. Your dishonesty and deceitfulness in not being true to your fiance are now making it difficult to be happy with him.

d. You are sorry for not being true to your fiance and are having a hard time confessing to him, especially since now he seems so boring.

3. Just because they are getting a divorce is no reason for them to hassle me. It's almost like they are fighting each other through me. I love them both and don't want to take sides. How can such wonderful people be so totally childish?

a. I wish they'd mind their own business and leave me alone.

b. Your parents are being childish and using or abusing you in their divorce struggle. You love them both so you don't want to be seen as taking sides.

c. It's so hard for you to see your parents breaking up that you just want to be left alone.

d. People who are going to get divorced shouldn't have children.

4. What's the big deal about being 33 years old and not married? I know lots of unmarried women, and they seem perfectly happy, but the way people talk, you'd think I'm some kind of freak or lesbian or something!

a. It's nobody's business whether or not you're married.

b. Time is running out for you. You're really an old maid and don't want to face up to it.

c. You're afraid that your sexual preference is confused and that you are a latent homosexual.

d. Being 33 and unmarried is no cause for concern. You know some women who appear to be happy and normal.

5. I want to be an auto mechanic, but at every school I go to, I get teased so badly about being a woman that I end up quitting. Should I change my goal?

a. You have been teased about wanting to be an auto mechanic so much that you have quit several training programs and are wondering about changing your goal.

b. You don't want to be a mechanic badly enough to put up with the teasing.

c. Equality in job opportunities is just a dream and won't ever happen.

d. There are times you'd really rather be a man.

6. My sister smokes pot. She is only fifteen. I'm afraid that she's on the wrong path, but she retorts that her peers' approval is more important to her than mine.

a. It makes you angry when your little sister doesn't do what you say.

b. Your sister's friends are leading her astray, and you think she should find some new friends.

c. You are afraid that your sister is doing wrong by smoking pot, but you can't do much about it because the influence of her peers is stronger than yours.

d. If pot were legalized, you would have no reason to be concerned about your sister's behavior.

III. Summary of Content. Assume that the six client statements in II-A were made by the same client in the same session and write a summary of content.

Responses for Comparison

I. Indirect Leads

A. New client

1. Tell me about yourself.
2. Share with me some background information.
3. Say something about yourself so I can get to know you a little better.
4. Describe for me the events leading up to your coming to see me.
5. How do you see your situation?
6. What perceptions do you have regarding your circumstances?

B. Continuing client

1. Fill me in on what's happened since last time.
2. How do you see things today?
3. Share with me your thoughts about....
4. What's happening with you now?
5. What's happened since we talked last?
6. I'd like you to begin talking about what's important to you now.

C. Label and analyze

1. Indirect, a good and very open lead.
2. Indirect, not very good because of the word, "Why." That particular word tends to evoke defensiveness.
3. Direct
4. Direct, weak because it forces a person to stop feeling long enough to think about it and because it can be answered in one word.

5. Direct
6. Indirect, basically a good lead. It does focus on a particular statement, thereby directing attention, but it's open enough to keep the client active.
7. Indirect, a good lead, focused.
8. Indirect, a good lead, a furthering response.
9. Direct
10. Indirect, okay, another furthering response.
11. Indirect, not very good. Includes, "Why" and directs attention toward the problem and away from the person.
12. Direct, terrible as an initiating lead because it is a social convention and not a request for communication.

II. Paraphrase of Content

B. Selection of best paraphrases of content. While more than one of the alternative responses for each situation may be acceptable and therapeutic, only the keyed responses are paraphrases of content.

1. c	4. d
2. a	5. a
3. b	6. c

Remember that a paraphrase of content does not add or subtract appreciably from what literally was said.

III. Summary of Content

The order is not necessarily significant, but each area of concern should be paraphrased along with most of its accompanying content. Compare your summary with this one:

You've expressed concern in six areas. There is the problem of being caught in the middle of your parents' divorce and not knowing how to maintain a neutral position; your Mexican vacation left you with the conflict of not knowing how to deal with a less-than-satisfactory fiance when compared to the relationship you enjoyed in Mexico. Money is a problem in that you may have to have your father help you, which makes you feel like a failure, but the $400 debt, auto insurance, tuition debt, and bank problems require some action; schooling is an issue, particularly since you're being teased so much about being a woman mechanic; you're experiencing some difficulty over your age and marital status; and your little sister has you worried in regard to her pot smoking and peer pressure.

Chapter III TRACKING SKILLS

In Chapter I, reference was made to the fact that progress beyond ventilation and through clarification, or movement in the funnel from surface to depth, usually requires assistance from a skilled helper. The skills most essential to this movement are referred to as "tracking skills."

An analogy is inherent in such a label. Picture a person wandering through a dense forest, not sure of his/her destination, confused as to how s/he got to the present location, doubtful of her/his ability to escape from the dilemma. Picture yourself as a competent scout, tracker, or explorer who knows the signs which show an earlier passage of a person, and who is wise in the ways of survival within and navigation through the forest.

Your task is to find the lost traveler, reassure him/her of basic ok-ness, develop a trusting relationship so s/he will let you be a guide, determine precisely where s/he wishes to go, and help her/him do what is necessary to get there. Note here that your task is not to get there "for him/her" or to carry the traveler on your back--for to do so may cause you both to perish--but rather to teach or coach your charge into making the appropriate and necessary steps by her/himself.

The first step is to find the lost traveler. You read many signs--crushed grass, broken twigs, remains of campfires, discarded items, footprints, etc. After a time you notice patterns of behavior which allow you to move ahead more quickly. You put yourself into the situation of the lost traveler, as nearly as you can imagine it, and say to yourself, "What would I do next?" Your conclusions from such

imagining allow you to make some shortcuts--some of which are in error but most of which are accurate because of your skill and awareness from similar experiences in the past.

Your task would be easier if the traveler remained in one place or behaved in a consistent, meaningful pattern; however, even as you are gaining an understanding of one day's wandering, the traveler is moving ahead.

Eventually you overtake the wanderer. S/he immediately expresses lots of emotion and eventually tells you how good it feels to have another person around. Of course the problem is not resolved until s/he can communicate an intended destination and can accept your guidance out of the predicament.

Focus for a moment on the tracking. You had to be simultaneously alert for clues in many forms; you had to see the obvious--the footprints, the discarded items--and the not so obvious--the crushed grass, the bent twigs. You had to imagine the emotional state of the wanderer and compute its effect within your awareness of the total situation. Only through having practiced such a complex process were you able to successfully perform your task.

Consider another analogy. The process of communicating through an advanced art form is an extremely complex and difficult, unless thoroughly practiced, process. Take a musical selection for example. To really understand and appreciate it, more than a superficial listening experience is necessary. One clue or one message may be offered by the most prominent melodic line, another by a secondary theme, still another by a countermelody. The structure or chords supporting the

melodies provides another message; the sequence of chords and their degree of adherence to or variation from a standard or predictable pattern tells a little more. The key structure, uniquely chosen for this selection adds information. The particular instruments or voices give special meaning. Even more can be "heard" from the selection if you know something about the composer--his/her personality, the physical and emotional environment in which s/he lived. All of the data, experienced as a complex whole provides a more nearly accurate communication between two people. Such a skill of being able to listen to or monitor several channels simultaneously, channels within the music and channels within yourself, is difficult to master but a tremendously gratifying one.

These analogies share the complexity of therapeutic counseling and require a similar degree of experience and practice. Their description rolls easily off the pen; their mastery is considerably more difficult.

Down the Funnel

As described earlier, a well-initiated counseling interview invites the client to expose content which has some meaning or significance to him/her. Without help to proceed toward more depth, the client will probably talk in content circles, periodically covering data which has already been discussed. Within the content of the superficial plane at the top of the funnel and parallel or simultaneous to it are "footprints, crushed grass, and bent twigs" which provide clues to a deeper meaning.

It is helpful to differentiate verbiage from message. Not always do words efficiently convey meaning; it is possible to talk at length

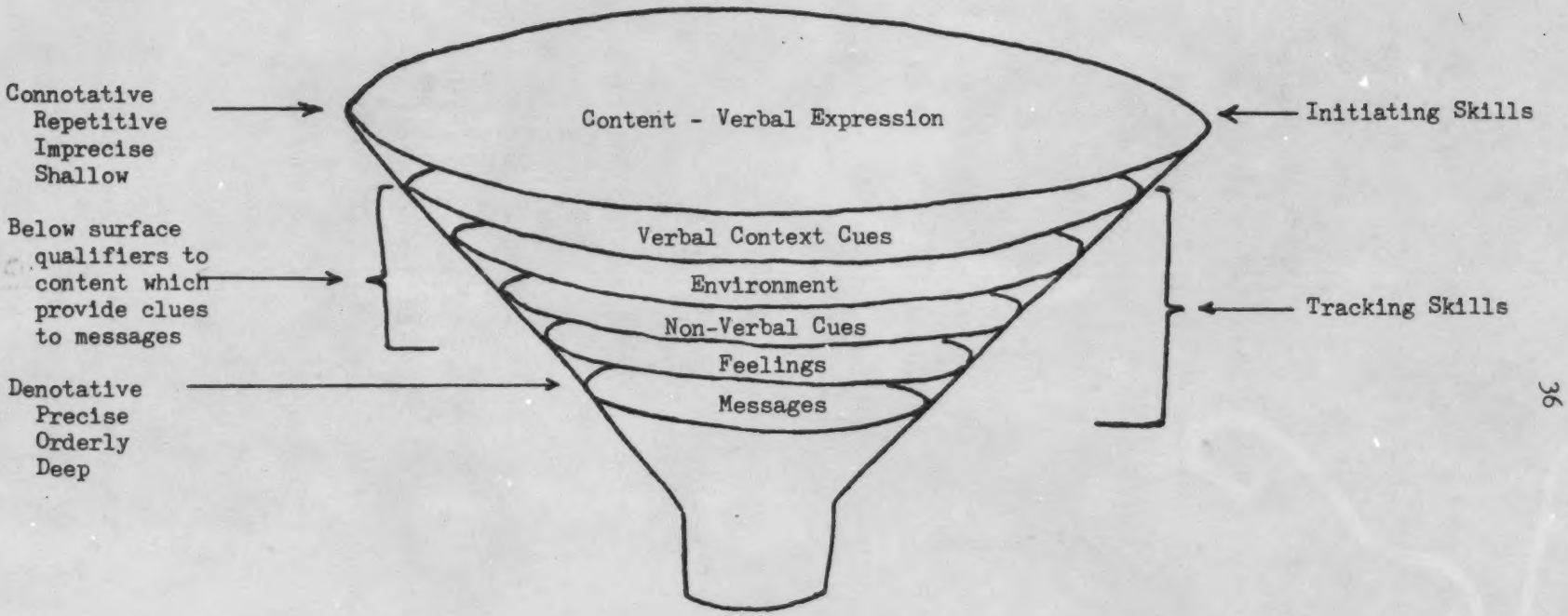
and yet say very little. Conversely, it is possible to utter few or no words and still communicate strong meaning. The words are verbiage; the meaning is message.

Verbiage ranges from empty or devoid of message to precise and complete message. Two divisions of verbiage are helpful: connotative and denotative. Connotative use of words is marked by imprecision and necessity to infer intended meaning. Denotative use of words is using them in readily understood, dictionary-type precision. Normal conversation is comprised usually of considerable amounts of connotative language, some proper denotative language, and some incorrectly used, wrongly defined denotative words.

Ascertaining intended meanings requires the use of multiple channel monitoring techniques. The words themselves form one channel; the context of the verbal structure is a second channel. Another context, that environment in which the words are shared, presents qualitative influences on messages. Non-verbal cues occur in yet another channel. The internal reactions of the therapist and his/her ability to conceptualize the client's words and other cues provide additional qualitative aspects of the communication process (see figure 2).

This is all further complicated by client production coming word-by-word, action-by-action in a linear fashion. The therapist must remember words, impressions, feelings, and observations in a continually active, kaleidoscopic mixture, scanning constantly for patterns and matching them against his/her own experiences.

Figure 2


Connotative
Repetitive
Imprecise
Shallow
Below surface qualifiers to content which provide clues to messages
Denotative
Precise
Orderly
Deep
Content - Verbal Expression
Verbal Context Cues
Environment
Non-Verbal Cues
Feelings
Messages
Initiating Skills
Tracking Skills

Paraphrasing Messages

The key to good therapy in the clarification phase is the skill of the therapist in "hearing" messages from the multiple channel monitoring, and then relating them back to the client in relatively simple, straightforward, denotative language. When confronted with an accurate translation of his/her confusing attempts at understanding and communicating her/his predicament, the client validates the accuracy of the therapist's paraphrase and simultaneously achieves personal insight.

Paraphrasing messages consists then of processing the complex inputs from the client and giving them back in a more precise form. It might well be preceded by the silent phrase, "What I understand your predicament to be is . . ." or "The message I'm hearing is . . ." or "What you really mean to say is . . ."

Some examples of paraphrased messages are:

> "You want very much to be successful, but can't quite bring yourself to try for fear of failure."
>
> "While it's hard to admit it out loud, you really dislike your mother and are angry at her for the way she treated you."

Several additional skills contribute to pinning down the real messages from a client. These are Reflection of Feeling, Description of Situation, and Formalizing Non-Verbal Cues. Each of these, by itself, will contribute to increased client awareness of her/his circumstances, but the strength of each is multiplied in combination with the others to refine paraphrases of messages.

Reflection of Feeling

Awareness of and appropriate expression of emotion is one mark of a well-adjusted person. Clients, almost by definition are not well-

adjusted in some respect, and often do not recognize or manage their emotions very well.

Being able to "mirror" client emotion (affect) by describing feelings in denotative terms (often referred to as labeling feelings) allows the client to be more aware of his/her feeling state and, at the same time, feel closer to the therapist who is so "understanding."

Sometimes a reflection of feeling is nothing more than a paraphrase of a connotative feeling statement. For example:

Client: "I'm really feeling bummed out by that last fight. She just doesn't fight fair. If she were at all logical, it would be easy to solve our problems."

Counselor: "You're very discouraged at your inability to communicate with her. Somehow her way of fighting confuses and irritates you."

Occasionally a reflection of feeling will be made from observation of a physical gesture or posture or facial motion. For example:

Client clenches fist while talking about his/her father.

Counselor: "You're quite angry at him for doing that to you."
(or) "Even though that happened years ago, you're still mad at him."

Client smiles while talking about advances by neighbor's husband.

Counselor: "It pleases you to be the object of a hustle."
(or) "Even though you think it's wrong to play around with another's husband, the thought of it is exciting to you."

Often there will be no words alluding to an emotional reaction or no physical manifestations of affect, and yet you, as therapist, suspect the presence of such emotions. Usually this impression comes from within you as you identify with the client's position. For example:

Client is talking in a calm, semi-relaxed voice about being held up last night at gunpoint.

Counselor: "I bet you're still feeling some tension in your stomach--afraid, even though it is over."

Not always does a reflection of feeling have to be verbal. On occasion it may be helpful to mirror the posture or gesture of the client; even an exaggeration by the therapist of the client's action will draw his/her attention to the feeling state and to the therapist's awareness of it. Sometimes, by adopting the posture of the client, the therapist can facilitate his/her awareness of the client's emotional state.

Description of Situation

In the process of relating a circumstance, condition, or happening, it is quite natural for the teller to leave out considerable amounts of data. Those data vary from unimportant, through significant but common (hence easily overlooked), to highly important. The teller operates from a greater awareness of his situation and omits data because they seem insignificant, or obvious, or because s/he is focusing intently on something else.

One of the foremost propositions of perception is that the figure (focus) takes meaning or significance from the ground (background data) in which it is imbedded.

The task of the therapist is to understand the circumstances, conditions, or happenings--in short, the situation--which is being incompletely described by the client. One way of validating that understanding is to infer and describe some of the parts missing in the narrative of the client. This is not as difficult as it may appear at first. It consists of the therapist putting him/herself in the circumstances of the client and "looking around." For example:

Client is a woman whose husband has just filed for divorce and there is reason for her to believe another woman is involved. Most of her comments are angry and hostile, directed at her husband.
Counselor says to self, "If I were in her situation, what would I be feeling? What would I be concerned about?"

Feelings and Concerns:
Anger toward husband
Love toward husband
Self-pity
What did I do wrong?
Where or how am I deficient to the extent he would want to replace me?
What has she got that I haven't?
How can I live without him?
I'll be better off without the rat.
I'll miss him a great deal.
What will happen to our children?
What'll I tell mama, the neighbors,--?
Will we have to sell the house and move?
If only he would come with me to counseling.
I should be strong and righteously indignant.
I feel weak and want him--or somebody--to make it feel better.

Another example:

Client is a college man who has been going with a girl back home for three years. He has just met and fallen "madly in love" with her cousin.
Counselor's thoughts in describing situation to him/herself:
"He does have a problem. There are obviously three ways out. He can go back to the old girlfriend; he can go to the new one (her cousin!); or he can leave both of them. He could try to string them both along--dumb! How would I feel in this situation?

Feelings:
Ambivalent toward old girlfriend
She has been good and faithful for three years.
I do love her, I think--but if I loved her, why would I fall for her cousin?
I don't want to hurt her.
She does seem a little plain, and the old fire is not there any more.

Ambivalent toward self
What kind of a creep am I? I can't just drop somebody who has stood by me for three years.
On the other hand, it would be stupid to stay with her if I don't love her.

Her cousin really rings my bell. I'd be foolish to let her get away.
C'mon now, I've only known her for a week. How can I put so much weight on such a short time?

Ambivalent toward the cousin
Wow! Is she a knockout! She could probably have any guy on campus.
I wonder if she really cares for me, or if I'm just a pastime?
Sure would be nice to spend forever with her.
Maybe the fire will go out and she'll be ordinary after a while.
Why'd it have to be her cousin? Well--probably doesn't make any difference anyway.

Obviously the therapist should not assume that the client is experiencing exactly what is imagined; however, the therapist's vicarious experience can provide a framework for making gentle, tentative inferences. These are most effective in the form of paraphrases or incomplete leads; e.g., "Part of you would really like to hurt your husband for what he's doing, but another part . . ." or, "How could I be so stupid, getting mixed up with her cousin? There must really be something loose in my head." Just as with an ordinary paraphrase or incomplete lead, the client will accept and validate it my moving further along, or will deny or correct it and move in a more accurate direction.

It is probably on the basis of descriptions of situations that a therapist can make careful, inferential leaps; that is, s/he can get out "in front of" the client, can move ahead of where the client is talking. If accurate, the inferential leap can save time and give the client an impression that the therapist <u>really</u> understands. If inaccurate or in error, the inferential leap will waste time and increase distance or create barriers between the therapist and client. A healthy degree of caution, small inferential leaps, and an air of tentativeness, therefore,

are imperative in using this technique. An old adage says that real artists paint in small strokes; likewise, real therapists infer in small leaps.

Formalizing Non-Verbal Cues

One of the many channels of communication, itself rather complex, is that of non-verbal cues. This channel has received lots of popular notice (Fast, 1970; Hall, 1959) and is even afforded by some the status of an area of scientific inquiry called proxemics (Birdwhistell, 1952). While the popular action may be mostly entertainment and the scientific status premature or over-done, there is value in therapy for the recognition of non-verbal cues.

Occasionally non-verbal behavior is the figure in the figure-ground framework; that is, it is intended to be the prominent mode of communication. Silence as a response to a direct and obvious question, gestures in the absence of verbal production, agressive or inviting movements without words--these are all examples of non-verbal, focused communication.

Extreme care must be exercised in instances like these, for the message is derived more from the context than from the focus. There is far less universal acceptance of the meaning of non-verbal behavior than even connotative language; therefore, such non-verbal production should be paraphrased in very denotative language to establish proper understanding.

More often, non-verbal cues form part of the context of message transmission and serve principally to alter the intensity of the message (increase or decrease) and to validate or invalidate the spoken words.

In such conditions, they are part of a paraphrase or reflection of feelings and remain contextual; for example:

> Client is clenching fists and gritting teeth as s/he talks about unfair treatment by a parent.
>
> Counselor: "You're very angry at your mother ..."

In this sense, non-verbal cues are not formalized but serve as very useful, qualitative clues for the intended message. As such, they are extremely important and comprise one channel of communication which requires constant monitoring.

Formalizing non-verbal cues consists of bringing them to the attention of the client, moving them from ground to figure, and processing their meaning. This is done when it seems that the client is separating his/her feeling self from the intellectual self or when the therapist wishes to confront the client with apparent inconsistencies. Some examples are:

> Counselor: "You are saying that you're disturbed somewhat by his behavior, and you are gripping my hand so tightly that it feels like your fingernails are going clear through. Are you more than somewhat disturbed?"
>
> Counselor: "Your mouth is telling me that you are really worried, extremely concerned, very nearly panicked by what you must do, and yet your body appears relaxed, comfortable, without a tension anywhere. How do you explain such a contrast?"

Managing the Tracking Skills

As was pointed out earlier, the essence of tracking is to hear messages by interpreting input from several channels of communication. It is important to realize that communication is a "two-way street" and that the therapist's actions have impact on the client. The following table gives the timing factors and rationale for the tracking skills.

Tracking Skill	When to Use	Rationale
Paraphrase of Message	As soon as messages are apparent and frequently thereafter	1) Helps client to clarify what is happening to her/him 2) Increases client self-awareness 3) Reinforces therapy process 4) Strengthens therapeutic relationships
Reflection of Feeling	As feelings become apparent from client statements and behavior, or when they seem to logically fit within the situation	1) Legitimizes feelings 2) Helps client to sharpen awareness of what he/she is experiencing emotionally 3) Shows understanding by therapist
Description of Situation	When enough clues are presented to support cautious inferences, and occasionally thereafter to sharpen understanding	1) Demonstrates therapist's understanding 2) Shows client that it is counterproductive to withhold information from therapist and from him/herself
Formalizing Non-Verbal Cues	When they directly transmit a major message When they validate verbalizations When they contradict verbalizations	1) Promotes client self-awareness 2) Shows therapist's understanding 3) Verification of messages and/or relative strength of message 4) Confrontation to clarify confusing messages and/or to cut through resistance

The exact timing and intended purpose will vary from client to client and from time to time with the same client. Much practice is required to properly develop mastery of these skills, and even the experienced therapist must constantly monitor their effectiveness and be prepared to alter her/his approach to better achieve the goals of therapy.

One of the frustrations for the neophyte counselor or student is knowing when to stress feelings, or ideas, or non-verbal messages, or situational cues. Being able to "hear" the various inputs is the first consideration. When several channels are carrying the same message, a counselor response to any one of them will probably be effective, but when a problem exists in the situation, a high feeling state is present, and the client is trying to understand what is happening, how does the counselor choose the channel which holds the most promise for movement toward resolution of the problem?

Experienced therapists seem to select the best or at least an acceptable response which provides smooth and rapid progress. They may do so because (1) they have developed a personal ability to conceptualize and communicate which is acceptable to most clients, or (2) they take a cue from the client for selection of response, or (3) they have a combination of conceptual ability and sensitivity.

These abilities may be of a logical nature; i.e., the ability to receive, remember, and process concepts from what the client has said. Selection of response, for some therapists at least, may depend on aural input--the sensitivity to volume, stress, inflection, or pace which gives cues to relative degrees of importance. Other counselors may rely on visual signals--posture, rate or change of rate in breathing,

color variations in complexion, eye movements--to help them select which lead to follow. Still others respond somewhat intuitively as a result of vicariously identifying with the client's circumstance and focus on whatever is prominent to their awareness.

One line of thought, Neuro Linguistic Programming (Bandler and Grinder, 1975, 1979 and Grinder and Bandler, 1976) suggests that clients provide clues not only for the focus of message but also for the kind of response they are primed to accept. It is postulated that clients develop a preference or style for dealing with their reality. The variations include the tendency for seeing, or for hearing, or for feeling to dominate. Bandler and Grinder contend that experienced therapists, of various theoretical persuasions, respond as though they were tuning in on client verbal and eye-movement cues. Clients who use "see verbs," as in "I see what you mean," and tend to look up in contemplation (up and right for constructing visual images, up and left for recreating eidetic or remembered images) have a model which emphasizes seeing as a means to dealing with reality.

People who use "hear verbs," as in "I hear what you're saying," and tend to look to the side or down and left in contemplation (to the right side for constructing auditory sounds or words, to the left side for remembering sounds or words, and down-left for processing auditory input) have a sound-centered model for functioning.

The use of "feel verbs," as in "I feel okay about that," and the tendency to look down and to the right shows the preference for a kinesthetic (also smell and taste) bias for organizing experience and coping with reality.

If clients do indeed have a systematic bias, then communicating to them in a manner consistent with their bias will likely enhance the relationship and facilitate exploration. Because each bias has some inherent limitations, the direction for therapeutic correction may involve re-structuring or re-programming the client to operate occasionally within less preferred styles.

This system provides an organized means of selecting responses from the various channels of client communication. Because it is organized, it may be helpful for students to develop it as a base for further refinement.

Summary of Messages

Because of the linear nature of communication and because it may take considerable time and effort to identify and process messages, it is helpful to summarize periodically the areas of concern to the client. This recognizes also that client concerns are often multiple, that their definitions are often confusing, and that delineations between or among them are frequently blurred or non-existent.

The occasional Summary of Message allows both the client and the therapist to visualize the gestalt formed by the separate messages and their interrelationships. Obviously the complexity of such patterns will vary greatly from client to client. A summary of messages for a relatively simple gestalt is as follows:

> Counselor: "You have described three major concerns which work against each other. First, you are not an extremely gifted student so that doing well requires great amounts of study. To make satisfactory progress and finish within five to six years, you must put virtually all of your time into school work.

Second, you are not wealthy, have borrowed more money than you're comfortable with doing, and so must work to maintain yourself and to pay for college expenses. Any time spent working is time away from your studies.

And third, you are a human being with needs for social interaction, variety, recreation, and occasional rest. Putting all your energy and time into school and work leaves none for emotional regeneration and so you feel depressed emotionally and physically drained most of the time. This in turn decreases your effectiveness both in school and at work."

Even though "relatively simple," the concerns of this client are multiple and difficult. Obviously, continued exploration and processing are necessary.

An example of a more complex summary of message is:

Counselor: "Let me see if I'm understanding your position. You are married to one person, but have been living separately for several years. He does not want a divorce but is doing nothing to get you back together. So one problem is to resolve your present marriage, but there are several sub-problems.

A) Your needs are not being met in your marriage--
B) You've given him the power position by refusing to take any initiative. Obviously he is more satisfied with the status quo than you are, or he would do something to change it.
C) You're afraid to take action because you might drive him away; you're not happy the way things are; but they could be worse.

A second major problem is that you have a friend to whom you are strongly attracted, but you're not sure of that relationship because you fear it's based on your strong need for someone. If you didn't need so much, he might not be so attractive.

Third, while you didn't intend to become physically involved and so took no precautions, you fear you are pregnant. This aggravates the other problems because:

A) Your present husband told you to "not get pregnant" and being so will reduce your chances of working things out with him.
B) You're not sure of your relationship with the other man, so marrying him for the baby's sake would be foolish; but if the relationship really is potentially good, not marrying him would be foolish. Mostly you don't want to be trapped into or out of any marriage.

A fourth complication is the fact that you work at the same place as this other man and, if the boss were to know what was happening, he would probably terminate your job. Since you are a probationary employee, you would have no recourse but to accept his action.

Fifth, you have really come down hard on yourself for
A) being unfaithful to your husband.
B) foolishly getting pregnant and going through the torment of deciding how to manage this circumstance.
C) rehashing how you have been a disappointment to your parents, yourself--everybody.
D) bringing up the feelings of how much better your sister has run her life.
E) reliving the unresolved feelings of your earlier illegitimate births and subsequent adoptions of your children.

While such summaries often contain overwhelming problems, they do clarify circumstances and provide the groundwork for a series of therapeutic interventions. It might be good to point out at this time that such complex circumstances do not lend themselves to a single therapeutic intervention strategy. When the circumstances are completely identified, it is possible that techniques involving behavior modification, value restructuring, affective integration, and social training may all apply to the same client.

The following extention of an earlier table gives timing and rationale for Summary of Messages:

Tracking Skill	When to Use	Rationale
Summary of Messages	Occasionally as part of processing When things bog down When making transition into solution analysis At end of session If contradictory, as a means of confronting the client with double messages	1) Formalizes the real problems 2) Separates components of complex situations into soluble pieces 3) Leveling and "calling the shots" as you see them Bottom Lining 4) Helps make transitions from session to session, or between parts of the process

Summary

Perhaps the most dynamic and most helpful part of the entire therapy process is tracking. Without the help of a skilled therapist, clients tend to wander around in the relatively superficial content and incorrect conclusion area at the "lip of the funnel." The tracking skills of Paraphrase of Message, Reflection of Feelings, Description of Situation, Formalization of Non-Verbal Cues, and Summary of Messages are systematically employed to verify meanings and to encourage deeper exploration on the part of the client.

Paraphrase of Message is used as soon as messages are apparent and frequently thereafter. Its purposes are to help the clients clarify what is happening to them, increase client self-awareness, reinforce the therapy process, and strengthen the therapeutic relationship.

Reflection of Feeling is used when feelings become obvious from client statements and behavior, or when they seem to fit logically within the situation. This skill demonstrates that feelings are a legitimate part of life and of therapy, helps clients to sharpen awareness of

what they are experiencing emotionally, and demonstrates understanding on the part of the therapist.

When enough clues are presented to support cautious inferences, the therapist may go beyond the client's disclosures and verbalize inferences about what must be going on. This is called Description of Situation. It is very powerful when done properly in demonstrating the therapist's understanding of the client's predicament, and in showing the client that it is counterproductive to withhold information from either the therapist or him/herself.

Formalization of Non-Verbal Cues consists of drawing the client's attention to such behavior and denotatively describing the therapist's interpretation or confusion as to its meaning. This skill is employed under three conditions:

1) When the cues directly transmit a major message. This promotes client self-awareness and shows understanding on the part of the therapist.

2) When the cues validate verbalizations; i.e., when they are congruent with the spoken messages. The message is verified by this technique, and gradations of intensity can be reflected.

3) When the cues contradict verbalization; i.e., when they are inconsistent or incongruent with the spoken messages. Formalizing the cues in this instance provides a confrontation with the client and generally serves to clarify confusing messages or to cut through client resistance.

Summary of Messages is employed occasionally as part of processing, when things bog down, when making transition into analysis of potential solutions, and at the end of a session. This serves to formalize real problems from less significant data, separates the component parts of

complex situations thus permitting resolution of sub-parts and analysis of the relationships between sub-parts, provides "bottom line" statements of what the therapist sees, and aids in making transitions between and within sessions.

By virtue of their seeking help, clients are not able to clarify, analyze, and resolve circumstances with which they are faced. Left to their own devices, they probably will repeat past errors. Tracking is the process by which a therapist monitors multiple channels of communication and teaches clients to observe and understand the meaning of their own experience.

Exercises: Chapter III

I. Paraphrase of Message

A. Write a paraphrase of message for each of the client statements in the exercises for Chapter II.

B. Write a paraphrase of message for the following:

1. When people ask me where I went to high school, I get tensed up. Harris High School is where all the delinquents and slow kids are sent.

2. It's so hard for me to get close to people. I want to be liked so much, and yet my conversations with people seem so superficial and empty.

3. I thought he liked me, that we had something special going, but when I asked him to meet my parents, he made an excuse about why he couldn't do that. He's been very cold toward me since.

4. I just don't understand it. My grades are okay in everything except my major. Usually I work hard to get all the less important homework done, then I have two or three hours, between 10:00 p.m. and 1:00 a.m. to do my chemistry and trig.

I work so hard on them, over and over again, but I just can't seem to get them.

5. I'm through for the season; maybe for good. The doctor said the operation went okay but that rehabilitation will be hard and will take a long time. Oh well, football isn't everything. I can be an outstanding accountant or a rich banker.

6. Sure, I drink the hard stuff occasionally. Just last week I tied one on like you'd never believe, but I can handle it. All that stuff about out-of-control drinking, booze in the morning, drinking alone--I've done all of those and I'm just fine--just fine.

C. Compare your paraphrases of message with the following examples and select the best for each example:

1. When people ask me where I went to high school, I get tensed up. Harris High School is where all the delinquents and slow kids are sent.

   a. It's nobody's business where you went to high school.

   b. You're not very proud of your actions during school.

   c. High school has some bad memories for you.

   d. Graduating from a good school helps your image.

2. It's so hard for me to get close to people. I want to be liked so much, and yet my conversations with people seem so superficial and empty.
   a. People don't find you to be very likable.
   b. If only you were an interesting conversationalist, then people would like you.
   c. You are emotionally isolated and don't know what to do about it.
   d. It's hard to get close to people like you want to. People are just not interested in talking about important matters.
3. I thought he liked me, that we had something special going, but when I asked him to meet my parents, he made an excuse about why he couldn't do that. He's been very cold toward me since.
   a. I assumed too much and now I have alienated him.
   b. I just know he'd like my folks. Why is he being difficult?
   c. It wasn't that I expected to get married right away. Those things take time.
   d. I wonder if he is interested in someone else.
4. I just don't understand it. My grades are okay in everything except my major. Usually I work hard to get all the less important homework done, then I have two or three hours, between 10:00 p.m. and 1:00 to do my chemistry and trig. I work so hard on them, over and over again, but I just can't seem to get them.

a. You're not very smart in chemistry and trigonometry.

b. You have a mental block when it comes to homework in your major.

c. Studying so late is interfering with your social life and you resent having to do it.

d. The studying you do while you're fresh is producing better results than that which you put off 'till last.

5. I'm through for the season; maybe for good. The doctor said the operation went okay but that rehabilitation will be hard and will take a long time. Oh well, football isn't everything. I can be an outstanding accountant or a rich banker.

a. Your attitude is healthy because you know that football isn't everything.

b. It's hard to talk yourself out of the disappointment you're feeling.

c. What's really important is succeeding at whatever you do.

d. Years from now, being a football player won't seem so important.

6. Sure, I drink the hard stuff occasionally. Just last week I tied one on like you'd never believe, but I can handle it. All that stuff about out-of-control drinking, booze in the morning, drinking alone--I've done all of those, and I'm just fine--just fine.

a. You don't believe all that stuff about drinking being bad for you.

b. Even though drinking is bad for others, you can handle it okay.

c. There are alcoholics and there are drunks. You're just a drunk.

d. Your drinking is causing you some concern. Maybe you aren't handling it as well as you'd like to believe.

II. Reflection of Feeling

A. Write a reflection of feeling for each of the client statements in the exercises for Chapter II.

B. Write a reflection of feeling for each of the client statements in the exercises for Chapter III: Paraphrases of Messages.

C. Write a reflection of feeling for the following.

1. I'm four weeks pregnant. My boyfriend won't marry me, and abortion is out; I don't really want a baby, at least not until I'm out of high school, but I can't stand the thought of giving it to some stranger. What am I going to do?!!!

2. The disease is progressive. Unless the doctors can achieve remission of symptoms, I will be totally dependent on my wife within two years. I would rather be dead than to be a burden on her.

3. He's been dead for three years now, but I can still remember how he looked that last Christmas; he was so happy and he made me feel like a school girl again.

4. Sometimes I have strange thoughts, things I could never tell anybody else. Does that mean I'm crazy?

5. All I do is watch T.V. I walk in the room and automatically flick on the set. Four or five hours later my work is not done; I've wasted all that time; what is the matter with me?

6. And then, I don't know what came over me, but I hit her! Again and again I hit her! Initially she cried, like any three year old would do, but then she just sort of lay there, whimpering to herself. What kind of a person would beat a child? What kind of a creep am I?

D. Compare your reflections of feeling with the following examples and select the best for each example.

1. I'm four weeks pregnant. My boyfriend won't marry me, and abortion is out; I don't really want a baby, at least not until I'm out of high school, but I can't stand the thought of giving it to some stranger. What am I going to do?!!!

   a. You're angry at your boyfriend for deserting you.
   b. You feel trapped and sort of panicky---
   c. You're upset because this happened while you are still in high school.
   d. You feel frightened at having to do it all on your own.

2. The disease is progressive. Unless the doctors can achieve remission of symptoms, I will be totally dependent on my wife within two years. I would rather be dead than to be a burden on her.
   a. It's hard not to feel sorry for yourself.
   b. You're angry at the doctors for not curing you.
   c. You're mad at God for letting this happen to you.
   d. You feel sorry for your wife.
3. He's been dead for three years now, but I can still remember how he looked that last Christmas; he was so happy, and he made me feel like a school girl again.
   a. The thought of your husband makes you sad again.
   b. You're greatful that he was such a good person.
   c. It's just no fun at all to be a widow.
   d. You miss him, but still get happiness from his memory.
4. Sometimes I have strange thoughts, things I could never tell anybody else. Does that mean I'm crazy?
   a. It's exciting to have weird thoughts.
   b. You're frustrated at not being able to share your thoughts.
   c. It's scary to have such thoughts; you're not sure of your sanity.
   d. You're a little curious as to whether or not you are crazy.
5. All I do is watch T.V. I walk in the room and automatically flick on the set. Four or five hours later my work is not done; I've wasted all that time; what is the matter with me?

a. You're pretty well disgusted with yourself over this T.V. habit.

b. You're afraid that you have T.V. addiction.

c. Wasting time makes you feel guilty.

d. You're ashamed to admit that the tube has control over you.

6. And then, I don't know what came over me, but I hit her! Again and again I hit her! Initially she cried, like any three year old would do, but then she just sort of lay there, whimpering to herself. What kind of a person would beat a child? What kind of a creep am I?

a. Whatever she did made you extremely angry.

b. You're puzzled about the personal characteristics of a child beater.

c. Because child abusers were abused by their parents, you're upset with your mother for making you do this.

d. You're very sorry for what happened and very much ashamed of yourself for doing it.

III. Description of Situation

Put yourself in the situations which are incompletely described below. Write as many ideas or feelings as you can which would be important to you in each of those circumstances. Then check your lists against those in the response section, III.

A. You have been in a serious automobile accident which affected your spinal cord in the lumbar region, leaving you paralyzed from the waist down.

B. After 15 years of fidelity to your spouse, you find yourself caught in an affair with your next-door neighbor.

C. You are the oldest child in a family with three younger sisters. For two years your father has been engaging you in incestuous activities.

D. At Grange High School you were a studentbody officer and a starter on the basketball team. After transferring to Urban Mammoth High School, you refuse to even try out for any sports or activities.

E. You've been separated from your wife and family for 12 months because of a remote work assignment. Next week you will return home.

F. Your husband has a violent temper, especially when he has been drinking. He beats you frequently and sometimes severely. You are at the battered women's shelter following one of the more severe beatings.

G. You're engaged to a person who is of a different race and religion from yours. Your parents are adamantly opposed to your marrying him.

H. You are a third quarterjunior, and you are flunking out of school.

I. Your spouse and two of your three children have just been killed in a fire which destroyed your home.

IV. The other tracking skills, along with most of the general enhancing skills in the following chapter, do not lend themselves to paper and pencil exercises. Careful review of the text and coached experiences in the presence of an accomplished therapist or trainer is the best procedure for mastering them.

Responses for Comparison

I. Paraphrase of Message

A. Compare your paraphrases of message for the client statements in Chapter II exercises with these:

1. You have managed poorly in regard to financial matters and are now forced to admit your failure to your father and to yourself.
2. Basically you're faced with a relationship you want and can't have, and with one you have and don't want.
3. Even though you want to remain neutral, you find yourself drawn into the conflict of your parents' divorce.
4. For some reason it's necessary for you to defend being 33 and unmarried.
5. Because you have been unable to cope with teasing, you are considering changing your goal.
6. Your sister's behavior is a problem for you but not for her.

C. 1. b 4. d
2. c 5. b
3. a 6. d

II. A. Compare your reflections of feeling for the client statements in Chapter II exercises with these:

1. You're embarrassed to admit that you've managed poorly.
2. It's very frustrating to have what you don't want and to want what you can't have.
3. You're angry at your parents for fighting through you.
4. You're a little anxious yourself about not being married. or--You resent it when others are critical of your being single.
5. You're quite discouraged.
6. You're worried about your sister.

B. Compare your reflections of feeling for the client statements in Chapter III: Paraphrase of Message with these:

1. You're embarrassed about attending Harris High.
2. You're lonely and a little bit desperate for some friendship.
3. You're disappointed with yourself for making a wrong assumption and angry at him for being cold toward you.
4. You're worried about failing some classes, and embarrassed that they are in your major.
5. You're really disappointed at not being able to play. It sounds like a little bit of "poor me" or self pity is creeping in there too.
6. Your drinking behavior has you a little bit worried.

D. 1. b 4. c
2. a 5. a
3. d 6. d

III. Description of Situation

Caution is necessary to avoid the assumption that all of the things in the following segments apply to a person in the situation described or that nothing else applies. These lists are only suggestive of possible dynamics and serve only as an aid in helping the client to explore and share her/his phenomenal space.

A. You have been in a serious automobile accident which affected your spinal cord in the lumbar region, leaving you paralyzed from the waist down.

Mourning

loss of ability
feel sorry for self
Why did it happen to me?

Loss of status

I'm not as good as others.
I'm not as good as I used to be.
Focus on handicap and what I can't do instead of on remaining abilities: What I can do.
I can't expect my wife to stay with me now.
I don't deserve to live in this condition.

Need to depend on others, ask for help or tolerance or understanding.

Anger

At other driver
At difficulties
At God

Guilt for being angry or short with spouse, parents, or others who try to help but don't really understand

Feeling of isolation--nobody understands
--nobody really cares

Embarrassment--at involuntary tremors or leg movements
--at perceiving the discomfort or condescension of others

Sensitive to buildings w/out ramps
restrooms without hand bars
words like cripple, handicapped

Overprotection by others--people treat me like I can't do anything. I still have lots of ability!

B. After 15 years of fidelity to your spouse, you find yourself caught in an affair with your next-door neighbor.

Guilt--What a terrible thing I've done!
What kind of a person am I?
How can I ever make it up to my spouse?
What will I tell mother?

Confusion--What should I do?
Should I leave?
Should I stay?
Suicide?
Should I go to the other person?

Surprise--I didn't intend to go that far.
How did it ever happen?
I didn't know it would cause so much pain.
I thought I would handle it better.

Frustration--My spouse seems to want more closeness and reassurance than ever, and from me. How can I be loving and reassuring when I feel so guilty and unworthy?

Dislike for myself

Rationalization--It's no big deal. Why is everyone so upset?

Remembering mostly good things from the past 15 years that are now in jeopardy because of my unfaithfulness.

Sorrow at the thought of losing children, home, status, friends.

C. You are the oldest child in a family with three younger sisters. For two years your father has been engaging you in incestuous activities.

It must have been my fault.

I am bad because I didn't stop it.

I am bad because I enjoyed it.

Daddy is a bad person; I hate him.
Daddy is a good person; I love him.
I wonder if he did the same thing to my sisters.
Mother didn't believe me at first.
Mother said I must have seduced him. She thinks it's my fault.
What will people think of me now?
I feel so dirty.
I am no longer desirable as a wife.
I have committed a grave sin.
I feel sorry for myself.
I'm not such a bad person. I didn't know what was happening.
It's not fair that I should suffer from what he did to me.
I don't want them to take him away.
My sisters need to be protected from him.
Mother should divorce him for doing that.
Why couldn't I have the kind of father that other people have?

D. At Grange High School you were a studentbody officer and a starter on the basketball team. After transferring to Urban Mammoth High School, you refuse to even try out for any sports or activities.

Overwhelmed
Doubtful of my abilities
Afraid to find out that I'm not good enough
Miss my old routine
Miss my old friends
Upset, maybe angry at having to move
Isolated and fearful
Don't know the expectations of teachers
Need to adjust to new rules
What if people don't like me?
I feel like a country cousin.

E. You've been separated from your wife and family for 12 months because of a remote work assignment. Next week you will return home.

Joy--I'm so happy to be going home.
It will be so nice to play with the kids again.
I've been lonely for my wife and now the long wait is over.
We're going to do so many neat things together.

Hesitation--Will things be the same?
Will she be happy to see me?
They are so used to getting along without me; will I be needed? Will I be intruding?
What will my role be in disciplining the kids?
Will our intimate relationship be okay?
Do they resent me for being gone?

Resolve--I'm going to make up for all the things we've missed out on.
Things will be better even than before I left.

Regret--I'm not too pleased at some of the things I did while I was gone.

Unsureness--Have my wife or children done things which I would not want them to do? Should I ask or just assume the best?

F. Your husband has a violent temper, especially when he has been drinking. He beats you frequently and sometimes severely. You are at the battered women's shelter following one of the more severe beatings.

I hate him.
I love him.
He's a good person.
He's a bad person.
He wouldn't have hit me if I didn't deserve it.
We'll work it out this time. It'll be better.
He's so nice to me when he's not drunk.
I know he didn't mean to hurt me.
I'll never go back.

I want to go back.

What else can I do? Where can I go? Who else would have me?

I need to be strong for my children's sake.

I could never divorce him. Divorce is bad.

I married him for better or worse.

I'm not a quitter.

Oh how I hate getting beaten up!

If I had a good job, I could leave him.

G. You're engaged to a person who is of a different race and religion from yours. Your parents are adamantly opposed to your marrying him/her.

I love him, and it doesn't matter what anyone else thinks.

I wonder if it's really wise to marry him/her.

Mom and dad will get used to the idea.

Sociologists say that the odds are against us.

I never was too much into my church anyway.

S/He'll change to my religion later.

It's hard to go against my parents.

I want them to like me.

Why do they compare me with my older sister/brother?

If I marry her/him, I'll never be able to go home again.

Is it really fair to our children?

If kids are loved, that's all that matters, and we'll love our children no matter how they look.

My parents have no right to try to control my life.

H. You are a third quarter junior, and you are flunking out of school.

I could do it if I really tried.

Maybe working full time and carrying a full load wasn't too smart.

I can always work on construction or join the Army.

I didn't really want to be an engineer anyway.

Dad will really be disappointed.

What a waste of time and money to flunk out after three years.

It wasn't all wasted. I got some good out of college.

Maybe I'm just not smart enough to succeed.

It's the teachers' fault. They didn't give me a chance.

What am I going to do now?

I. Your spouse and two of your three children have just been killed in a fire which destroyed your home.

I should have; if only I had; they'd be alive now if I had: come home earlier, checked the fire alarms, practiced fire drills.

Why couldn't it have been me instead. I wish I were dead.

I must live for my remaining child.

How can I go on w/out my spouse.

I can't believe this is happening.

Why did it have to happen?

It's not fair.

They were so happy, so full of life.

I'm going to miss them so much.

I must go on!

I've got to be strong!

I hurt so much!

What about the funeral? the insurance settlement? the relatives?

I'm so thankful for friends and family.

They just don't understand.

Why are they all looking at me in pity? Go away! Leave me alone!

Don't leave me alone! Help me! Hold me!

Chapter IV ENHANCING SKILLS: GENERAL

The term "processing" has been used a number of times in explanations of tracking skills. As such, it pertains to mulling over, sorting, and sifting the data of the counseling interaction. It should be differentiated from procedures like those which are used for processing foods, i.e., the systematic steps taken to prepare or to preserve foods. The counseling process is not so easily programmed into a set of procedures and sequences that are followed with each and every client. Therapists do not process clients; rather, they help clients to process their awareness of personal circumstances.

There are some general guidelines and suggestions which facilitate therapy, and there are certain techniques which, when properly applied, enhance the process.

General Guidelines and Suggestions

Three general objectives of processing are: (1) increasing the perceptual field of the client, (2) altering the focus from distant and past to the present--here and now, and (3) avoiding certain therapist actions which work against the first two.

It is common for people seeking help to have narrowed their perception so much that they can see only one or two alternatives, neither of which is acceptable or possible. It's a little like someone pushing on a door that opens inward.

Increasing the perceptual field pertains to both the internal as well as external fields. Being aware of emotional needs and responses, of value guides and limits and stress, of abilities and confidences, and of habitual responses and limitations is important in most problem

resolutions and is critical in some. This is so important that some entire therapeutic methods are directed toward getting in touch with feelings, value establishment and/or alteration, self-concept building or strengthening, and habit alteration. These special methods will be addressed in Chapter V.

Increasing the external field is concerned mostly with studying and evaluating conditions which are facilitative or inhibitive of problem resolution. It can safely be said that for each client and for each problem there are many more than the two or three options that he/she has been grappling with. In most cases, there exists a myriad of choices ranging from terribly bad to impossibly good and with a whole bunch of mid-range choices, any one of which could prove to be entirely satisfactory.

Usually a proper and effective processing of client circumstances requires an altered perceptual reference. The really important frame of reference is the one internal to the client. How does s/he see things, feel about things, hear things, value things, approach or avoid things, experience things? It is only from the client's frame of reference that circumstances can be thoroughly understood. It is only based on the client's understanding that successful coping activities can be generated and carried through.

Unfortunately, there is a tendency for many, perhaps most people, to respond to reality as interpreted from an external frame of reference, i.e., father's interpretation, society's interpretation. If I am extremely concerned with how I <u>should</u> see things or how I'm told to see them, I can't be very effective at seeing them as they relate to <u>me</u>.

The therapeutic process usually involves moving from an external frame of reference to the client's internal frame of reference. For example:

> Client: "People should be responsible for themselves and others. They aren't supposed to treat each other so badly."
>
> Counselor: "You are concerned, maybe angry at the way you're being treated."

Another simple fact that frequently escapes the client and inexperienced helpers has to do with time. Concerns and feelings are in the present; they exist now. Their antecedents may lie in the past or in the future, but they are now and they are here. Understanding and planning for resolution of concerns and aberrant feelings also occur in the present. Often client verbalizations are focused on distant times and places; they talk of then and there. Good therapeutic dynamics involve moving from then and there, to here and now. For example:

> Client: "My father was always mean to me when I was little."
>
> Counselor: "You are upset with your father for the way he treated you."

The therapist's role is to explore with clients their concerns and feelings and to teach them in the process to be thorough and non-defensive, to own their problems, and to take a responsible and active part in solving them.

There are some things that the therapist generally should avoid doing. Mostly they work against the principles just explained. Six general examples are as follows:

1) Giving personal examples
2) Providing answers to personal questions such as, "How old are you?" or "How long since you got your license?"
3) Giving advice

The above three are all responses out of the counselor's frame of reference. At best they are harmless, but even so, they prevent focus on the client where it must be in order for therapeutic progress to occur.

4) Stating "I know how you feel." While it's tempting to speak so authoritatively and knowingly, such a statement is basically not true. I don't/can't know how anybody else feels, and to say I do typically invites a challenge to that statement. "I understand," is another invitation to challenge.

5) Asserting the therapist's attitudinal set on the client. It's more productive to let him/her lead. If a position on an issue must be presented, care should be taken to present several positions and alternatives in addition to the one preferred by the therapist. If biases need to be stated, they should be clearly labeled as such.

6) Expressing sympathy. If the therapist takes on the client's frame of reference, he can only sympathize and hurt with the client; this helps neither person. A good therapist maintains an objective distance.

By focusing on those activities and skills which foster increased client awareness within the client's frame of reference and by avoiding things which detract from those goals, the therapist facilitates direct and efficient progress toward problem resolution. The initiating skills of Chapter II and the tracking skills of Chapter III are consistent with these objectives in therapeutic processing. In addition, there are some general process enhancers which form an essential portion of a therapist's repertoire of skills.

General Process Enhancers

There are skills which help the client to become more aware of internal and external conditions, facilitate ventilation, and promote problem definition which differ slightly from initiating and tracking skills in that they do not fit neatly into a sequence which parallels

depth of communication. Some occur rarely; others operate continuously; all enhance the process set in motion by proper use of initiating and tracking skills.

These skills, the General Process Enhancers, are different also from the theory specific, goal directed skills which tend to be mutually exclusive of each other and, therefore, which are best used each by itself in a theory-pure, therapeutically efficient manner. The Specific Process Enhancers will be described in Chapter V.

The General Process Enhancers are dealt with under the labels Perception Checking, Proper Use of Silence, Pacing, Physical Contact--Touch, Minimizing Interrogation, and Managing the Process. These labels, much the same as earlier ones used in previous chapters, at present have no universality of meaning. Some will be encountered in presentations on communication, counseling, therapy, human relations, and elsewhere. The reader is cautioned to study the definitions and descriptions which follow in order to understand the behavior and experiences keyed by the labels.

Perception Checking Virtually all of the initiating and tracking skills permit the therapist to form impressions or perceptions of a client's condition. Almost all replies by the client to such skills permit the therapist to test, "check," validate his/her perceptions. Perception checking as a technique, however, refers to a special use and modification of those skills.

Whenever the therapist precedes or follows a paraphrase, reflection of feeling, description of situation, etc., with one of the following phrases or its equivalent, s/he is Perception Checking:

"Tell me if I'm right. . ."
"Let's see if I'm understanding correctly. . ."
"Correct me if I'm wrong. . ."
"Is this the way you see it?"
"Am I right?"
"Have I got it down accurately?"
"Am I seeing it right?"

The effect of such therapist statements is to slow the process, invite an intellectual response from the client by asking the client to evaluate the therapist's statement, and produce an interrogative lead. If the Perception Check is accurate or reasonably close, the client may well reply, "Yes," or "That's right." If inaccurate, the client can change dramatically the interaction by simply saying, "No," or "You don't understand." Usually, however, the client will attempt to make a clarification and correct the misunderstanding of the therapist.

Because of the slowing, stopping, or confounding of process resulting from its use, Perception Checking should be employed rarely and only in those situations which clearly call for it. Primarily those conditions are when the client is markedly defensive and not receptive to the usually more effective techniques; the Perception Check in this case tends to soften the impact of the tracking skill.

Occasionally, too, it is helpful for the client to rehearse intellectually what s/he has been saying, to confront an awareness of his/her conditions, and to own them. This promotes an integration of affect, intellect, and history for the client and usually leads well into a personal analysis and sorting of conditions and their meanings. Used in this way, Perception Checking is a useful device.

Proper Use of Silence Even as the artist employs blank spaces and the composer of music accentuates sound by periodic quiet, so too does the therapist use silence in technical and artistic ways. Silence is more than just relief from noise or action; the presence of silence does not indicate absence of productivity.

Silence is unstructured time which has two qualities. One is pressure to fill it. Most people become uncomfortable with silence of more than a few seconds when they are in someone else's company; therefore, therapist silence is a subtle pressure for client talk. Since the client knows most about him/herself and the therapist needs input from the client, therapist silence provides a support for the, "You talk, I listen," dynamic of productive therapy.

This is not to say that the interview should include lots of long, awkward silences or that the therapist should never break silences. It does place proper emphasis on client production and disclosure.

A second quality of unstructured time is that of permitting thought, memory, feeling, and/or awareness on the part of the client. Particularly with difficult content or painful disclosure, the therapist needs a well-developed patience. Even in instances where it seems quite obvious what the client wants or intends to say, there is merit in letting her/him say it rather than doing it for the client.

So silence will occur early and frequently in a good therapeutic interaction. Certainly it will appear after each paraphrase, reflection of feeling, description of situation, after virtually every counselor lead or response. The length of the silence probably is a function of the client, who will break the great majority of the silences.

Occasionally, a period of silence will be directed by the therapist; e.g., "Now just sit quietly for a time and focus on your feelings. . ." Such use of silence is intended to produce additional insight and data for processing.

Pacing One technique which can be useful to the therapist in achieving more complete awareness of the client's experience is called pacing. Some therapists employ this technique to all their clients; others use it selectively for times when they are experiencing difficulty from reliance on their customary techniques. At least one approach contends that pacing and its companion technique, mirroring, are integral to effective therapy. From that source, pacing and mirroring are defined in this manner:

> To the extent that you can match another person's behavior, both verbally and non-verbally, you will be pacing their experience. Mirroring is the essence of what most people call rapport....You can mirror the other person's predicates and syntax, body posture, breathing, voice tone and tempo, facial expression, eye blinks, etc. (Bandler and Grinder, 1979, p. 79).

Because pacing is not universally accepted as critical to all therapy, yet appears to be effective in enhancing the tracking process, it is included here, perhaps in an altered form, as a general process enhancer.

Much the same way that marching in step with others in a precision drill team produces a feeling of togetherness and unity of experience, so too does "breathing" in step or "sitting" in step or matching volume or speed of talking produce for the therapist some additional insight into the client's state of being.

There is an important caution to be noted here. Body posture, breathing rythm, voice volume or speed are not necessarily universal correlates to the same experience. What the counselor achieves by shallow and rapid breathing gives access to her/his own past experiences which fit with that breathing pattern. This provides a hint to what the client may be experiencing; this hint can then be verified. The caution is against believing that the therapist's copy of the client's behavior provides direct access to the client's experience. In the same manner that specific words do not always correspond to identical meanings for different people, specific behavioral manifestations do not signify the same experience for everyone.

The primary value in pacing is the provision of suggestive data which can be verified by mirroring actions back to the client, formalizing of non-verbal cues brought to awareness by pacing, and paraphrasing messages or reflecting feelings that are cued by the pacing process.

Physical Contact--Touch Some specialized therapies use extensive physical contact on the theoretical basis that a person's mental or emotional condition affects the body and that direct manipulation of the body will, in turn, have a positive effect on the emotional or mental state (Lowen, 1975). Philosophers have debated, for centuries, whether people are dualistic (mind-body or spirit-body) or monistic and thoroughly integrated (Reich, 1927, Lowen, 1975).

Such underpinnings may be important for use of physical contact for achieving a specific therapeutic goal. For purposes of forming a therapeutic relationship, initiating, tracking, and processing of client information, the theoretical issues are not of primary importance.

Pragmatically, selective use of physical touch provides enhancement for the early stages of therapy.

Parenthetically it should be stated that there appear to be rather great individual differences between and among clients and therapists relative to the effects of touch. On one extreme, touch can be interpreted as a violation of self by the client, thereby producing a personal resistance to counseling. On the other hand, some clients seem to require touch in order to risk any personal affect in a relationship. Some counselors are so uncomfortable with touching that to do so would be interpreted as artificial and "techniquey:" others communicate quite naturally and genuinely through physical contact.

Certain agencies and some social groups prohibit or discourage touch, fearing accusations of legal or moral infractions. Of course some physical contact can be inappropriate, counterproductive, and even harmful to therapy. The Code of Ethics (A.P.A.) treats selfish manipulation of any kind, including touch, as improper and unethical. It specifically mentions sexual relationships between therapist and client as being unethical.

There are many variables in the process of physical touch as part of a relationship. Like fire, it has the potential of enhancement or destruction, depending on how it is used. To use touch carelessly is certainly wrong; to avoid its use when appropriate and therapeutic may also be wrong (Mintz, 1969).

In addition to being careful and timely with touch, the manner of touching is important. The variations are numerous and difficult to define; however, here are three continua for consideration: (1) intensity--

soft vs. hard, (2) speed--slow vs. fast, and (3) quality--supportive vs. seductive or manipulative. Therapist needs and style must be constantly monitored. "Whose needs are being served at this time," and, even if the client's, "Are those needs appropriately served in a professional, therapeutic relationship," are two questions which are important to all counseling activities, and especially to those involving physical contact. A third question which serves as a selective control in this regard is: "What is the probability of my touch being misinterpreted by my client?"

For clients who are not repulsed by touch, the following uses appear to be safe and warranted:

1) Upon introduction--a handshake or similar social amenity.
2) At the beginning of each successive interview.
3) Holding hand(s) or a hug as a signal to release pent-up affect; i.e., as an invitation to cry.
4) For reassurance and support after a particularly difficult disclosure.
5) At the end of sessions.
6) Occasionally to dramatize obvious body tension--usually accompanying Formalization of Non-Verbal Cues.

Probably a good rule for beginning therapists is, "Too little touch is better than too much." Being cautious is good, but risking a touch response when it "feels" right will allow the therapist to develop a sensitive and powerful therapeutic skill. In many ways, psychotherapy is like an advanced art form. Much can be learned from observing a skilled therapist; perhaps this is true in the area of physical touch more than with any other therapeutic skill.

Minimizing Interrogation The most frequent mistake of neophyte counselors is reliance on interrogative leads. This is such a problem that it merits the only negatively stated one of the Sequential Initiating,

Tracking, and Enhancing skills (SITE). "Thou shalt not interrogate!"

Some elaboration is necessary here. Actually any question fits within the interrogative category. Interrogation, in the sense here employed, refers to over-dependence on closed questions; i.e., those that can be answered with a "yes" or "no" or with a one or two word reply. The "grilling" of a criminal suspect by an over-zealous detective provides the stereotype for interrogation as used here.

Why is interrogation so bad? First, it is inefficient. If there are 100 possible questions, the odds of asking the important one is only one in a hundred. Even if the important question is asked, it can receive a partially true or untrue reply.

Second, and more importantly, interrogative interaction gives the client the power and the therapist the responsibility. The counselor must do all the work with relatively little direction from the client. It requires the client to know what is going on within him/herself and to understand the therapist's framework upon which the questions are based. If clients could do this, they would have little or no need for counselors.

Avoiding interrogation reinforces the use of indirect leads, paraphrases, and other more powerful techniques.

Managing the Process If a therapist is to be effective s/he must be expert at managing the therapeutic process. Clients do not know how to be good clients; they must be shown. They come to be "counseled" or helped or fixed or whatever. Many believe that they are coming to receive "the answer" or to be enlightened, guru style.

The therapist, through his/her management of process, is responsible to make things happen which result in an improved state for the client. All of the techniques described thus far are important in properly managing the process.

Obviously the engaging in interrogation, chit-chat, gossip, or any other non-therapeutic interaction constitutes mismanagement of process.

Some questions help to evaluate whether or not the interaction is on track:

1) Who's doing most of the talking?
2) Who's in control?
3) Is there lots of paraphrasing?
4) Is interrogation absent or minimal?
5) Are therapist responses consistent with or appropriate to the state of the client?

The client should be talking most, with the counselor doing the tracking and processing from a position of control. Lots of paraphrasing and little interrogation typically mark a good interaction.

It is important to make a distinction between process control and content control. The client is in charge of content. S/he has the information and the concern and therefore should be allowed and helped to set the direction, to get to the spout of the funnel. The "how" of therapy is the responsibility of the therapist.

Gazda et.al., (1977) have developed a scale for evaluating effectiveness of counselor responses. Basically a technically accurate use of the SITE skills will produce consistently a moderately therapeutic performance on their scale. To go beyond being moderately therapeutic

requires lots of practice, feedback, and the development of multichannel monitoring and understanding to an almost intuitive level. The therapist becomes an intensely functioning therapeutic instrument.

Not everyone can be expected to achieve excellence in managing the therapeutic process. Fortunately there are applications of the skills in many settings which do not require extremely high levels of therapeutic performance.

For those who have the talent, training, and perseverance necessary to be truly therapeutic, theirs is a unique experience of being.

Summary

Objectives of therapeutic processing include increasing both the internal and external perceptual fields of the client. To accomplish these, it is recommended that processing be rooted in the client's condition as seen by him/her.

Movement of attention from data and experiences that happened in distant times and places to events and experiences in the present is necessary for resolving problems which may have originated elsewhere but must be understood and resolved here and now.

Some things to avoid which are counterproductive are therapist reference to her/his personal experience, answers to personal data questions, giving advice, saying "I know how you feel," stating personal values or biases, and giving sympathy.

There are some skills which work in a general sense to enhance the therapeutic process. Some show up frequently in most therapy sessions; others receive selective use at appropriate times. These General Process

Enhancers are labeled Perception Checking, Proper use of Silence, Pacing, Physical Contact--Touch, Minimizing Interrogation, and Managing the Process.

Practical and sensitive use of all the SITE skills will produce a truly therapeutic experience.

Exercises: Chapter IV

I. Perception Check

A. Write a perception check for each of the client statements in exercises I-B and II-C of exercises for Chapter III.

B. From the following list, select responses which are perception checks:

1. You feel angry at him for doing that!
2. You believe that he cheated you; am I right?
3. Now is this how it is? He withdrew money from your joint account without you knowing?
4. Some days it just doesn't pay to get out of bed.
5. I have this vision of you blindly consenting to his request. How does it match with reality?
6. He doesn't admit to doing anything wrong?

II. Silence

Answer the following questions:

A. What are the two qualities of unstructured time?

B. At what times or under what conditions does silence occur in a good therapeutic session?

C. What are three possible interpretations for silence on the part of the client?

III. Pacing

Describe four ways of pacing a client.

IV. Physical Contact--Touch

A. Imagine yourself as a therapist. In what ways and under what conditions would you comfortably touch a(n):

1. child, 5 years of age?
2. prostitute who is trying to reform?
3. cancer patient, male, middle-aged?
4. 30 year old, female, amputee?
5. each of the above if Mexican-American, Black, Native American?
6. elderly man prone to bowel and bladder incontinence?

B. What three questions are helpful guidelines for proper use of therapeutic touch?

V. Minimizing Interrogation

A. Try to spend one entire day without asking a question which can be answered with one or two words.

B. Substitute an indirect lead for each of the following questions:

1. How old are you?
2. Why are you here?
3. Have you tried asking for a loan?
4. Did your mother love you?
5. Are you really depressed?

VI. Managing the Process

List the five questions which are useful in evaluating the counseling process.

VII. Applications

For the following situations, write three counselor actions which would be acceptable and probably useful. Do not limit yourself to Chapter IV skills.

A. Sally comes from an extremely conservative, rigid home environment. She has been complaining about an empty feeling deep inside. She starts to cry softly.

1.

2.

3.

B. Harry is relating, in a matter-of-fact way, how he is two weeks behind schedule and will lose his job if he doesn't catch up quickly. Although his voice is calm, his foot is tapping quite rapidly, and there is a half-smile on his face.

1.

2.

3.

Responses for Comparison

I. Perception Check

A. (I-B, Chapter III)

1. Is it true that you're not very proud of your actions during school?
2. Correct me if I'm wrong; you are emotionally isolated and don't know what to do about it.
3. You assumed too much, and now you have alienated him; is that right?
4. Let's see if I'm understanding correctly; the studying you do while you're fresh is producing better results than that which you put off 'till last?

5. What I'm hearing is you trying hard to talk yourself out of the disappointment you're feeling; how close to right am I?
6. How does this fit? Your drinking is causing you some concern. Maybe you aren't handling it as well as you'd like to believe.

(II-C, Chapter III)

1. Let's see if I've got it; you feel trapped and sort of panicky?
2. Am I right that it's hard not to feel sorry for yourself?
3. Is this the way you see it? You miss him, but still get happiness from his memory?
4. Correct me if I'm wrong, but it's really scary to have such thoughts; you're not sure of your sanity.
5. You're pretty well disgusted with yourself over this T.V. habit; is that right?
6. What you're feeling is sorrow and shame for what you did; am I correct?

B. Numbers 2, 3, 5 are perception checks.

II. Silence

A. pressure to fill it and permission to think, feel, remember, or increase awareness.

B. early and frequently

after each paraphrase, reflection of feeling, description of situation, almost all counselor leads or responses.

occasionally directed by the therapist

C. confusion

management of emotion; e.g., holding back tears, afraid to answer

resistance

composing or rehearsing a response

There are other reasons which are evident sometimes from the context in which silence occurs. It is permissable and appropriate to ask a client what s/he is being silent about, or to paraphrase from the cues which are present.

III. Pacing

breathing in the same rythm as client
assuming the same posture
speaking with the same volume
speaking at the same speed
making the same gestures
looking in the same direction
using some of the same key words in the same way

IV. Physical Contact--Touch

A. Analyze your imaginary encounters with the make-believe clients relative to whether you varied your touch patterns out of personal concern (for yourself) or out of concern for each of them. Because there are so many variables involved, it is impossible to describe a specific, always correct manner of touch for these examples.

B. Whose needs are being served at this time?

Are those needs appropriately served in a professional, therapeutic relationship?

What is the probability of my touch being misinterpreted by my client?

V. Minimizing Interrogation

A. This is just an exercise in avoiding interrogation. It is not a prescription for regular behavior. There are lots of occasions when interrogation is appropriate and efficient. It is possible, however, to substitute indirect leads for many instances of habitual interrogation.

B. 1. Tell me about yourself.
Give me some personal data.
Describe yourself to me.

2. Share with me your reasons for coming.
What events led up to your being here?

3. What things have you already tried in working on this problem?
Describe for me what you have already done.
What options have you considered?

4. Tell me about your childhood.
Describe your family relationship.
Tell me how you and your mother got along.
Give me some examples of how you related with your parents.

5. Tell me how you arrived at your present condition.
What symptoms or experiences cause you to believe you're depressed?

VI. Managing the Process

Learning to manage the process requires lots of experience and cannot be neatly expressed in a written exercise. The criteria for evaluating good management are:

Who's doing most of the talking?
Who's in control?
Is there lots of paraphrasing?
Is interrogation absent or minimal?
Are therapist responses consistent with or appropriate to the cognitive, affective, and behavioral state of the client?

VII. Applications

A. 1. Nothing

2. Hand her a Kleenex and say, "It's okay to cry."

3. Pace her posture and expression.

4. Reflect feeling.

5. Describe situation; maybe use an analogy.

6. Take hold of her hand(s) slowly and not too firmly.

B. 1. Formalize the non-verbal inconsistency with the verbal content.

2. Pace the foot tapping and mirror it back in exaggerated form.

3. Reflect feeling of tension.

4. Paraphrase message.

5. Silence.

6. Perception check the urgency expressed by the tapping foot and words about losing his job.

Chapter V ENHANCING SKILLS: SPECIFIC

Appropriate and effective use of the SITE skills described in the previous chapters results in the establishment of a communication process, a therapeutic relationship, and clarification of client style and circumstance. Once these are accomplished, therapy of a more problem-specific and style-specific nature can be started.

Parenthetically, it is important to point out that highly proficient, experienced therapists may move through the SITE sequence very rapidly and with surprising perceptiveness. Observers, and even clients themselves, often say, "How did you know?" or "Where did you get that awareness?" It is this rapid and efficient early-stage performance that obscures the commonality of therapists from different "schools" or theoretical identities. No one pays a lot of attention to foundations when the superstructures are rich and varied. It may have been the common nature of therapeutic foundations which led Hans Strupp to say, "No single school of therapy has a monopoly on the truth, and when all is said and done we shall probably find that their basic similarities are more impressive than their alleged differences" (Strupp, 1968, p. 97).

Having identified client style and circumstance, the obvious next step is to institute an action that will resolve circumstantial problems in the most effective manner relative to the style and resources of the client. This is the point at which the philosophical premises and psychological dynamics of various methods become critical. Application of a symptom removal technique to an affective denial problem or to a value confusion issue would be ineffective and foolish. Treating a compound

problem or a complex set of problems with a single, narrow-focus technique would be unsatisfactory; and use of a single emphasis, contaminated theory, eclectic approach would be counterproductive and maybe even harmful.

The preferred treatment procedure is to identify style and circumstances, sort out the differentiable problem(s), and seek resolution by applying intact, theory-pure, specific enhancers to the problem(s) appropriate to their dynamics.

By way of digression, the lure of eclecticism is strong. Dimond, et.al. (1978, p. 239) say, "... it is safe to conclude that most psychotherapists perceive their practice as embodying some aspects of an eclectic model." They procede to outline their preference for an improved, prescriptive eclecticism.

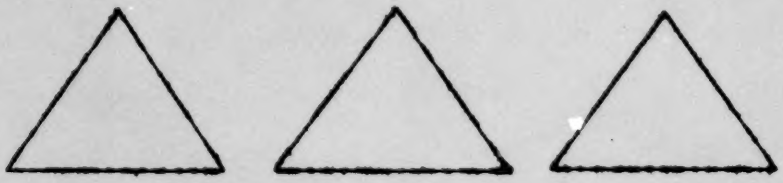
> The concept of prescriptive eclecticism in psychotherapy is an effort to integrate the ideas, concepts, and techniques of many psychotherapists into a broad framework that permits and facilitates the development of patient-specific treatment strategies. (1978, p. 239)

The goal of patient-specific strategies is admirable; the approach of eclecticism is foolish and counterproductive. One further quote which may help clarify this position is: "A basic postulate of prescriptive psychotherapy is that practitioners pay total allegiance to no single theory of personality and yet accept useful information from all of them" (Dimond, et.al., 1978, p. 241). Accepting something from all of them is markedly different and inferior to using each of them, intact, and applied to that problem or situation for which it is the most efficient, most appropriate, specific approach.

Internal Congruence: An analog for the goal of therapy

To aid in differentiating the various approaches to therapy, this section will present an analogy from geometry to positive mental health, which in turn can be seen as a global end-point to therapy.

In the study of geometry, the term "congruence" refers to the state of exact correspondence between two figures when they are superimposed; particularly pertaining to two triangles having equal legs and equal angles. The three triangles below are congruent because superimposition of the three would leave no part of any one hanging over or protruding from the others.

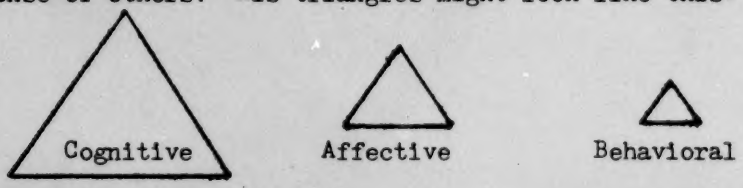


The nature of personality is often broken down into several component parts. A fairly common division includes: (a) the intellectual, thinking, or cognitive part of a person's experience; (b) the feeling, emotional, or affective part; and (c) the active, doing, or behavioral part. Some people might wish to include a sensing or experiencing part, and others would include a spiritual part. For our purposes, consideration of the first three--cognitive, affective, and behavioral--will suffice. Albert Ellis describes a similar viewpoint in differentiating treatment modalities into the categories of perceptual-cognitive, emotional and motivational, and motor and habituation (1968, pp. 91-92).

If the previous three triangles are labeled cognitive, affective, and behavioral, a visual definition of positive mental health or adjustment can be achieved.

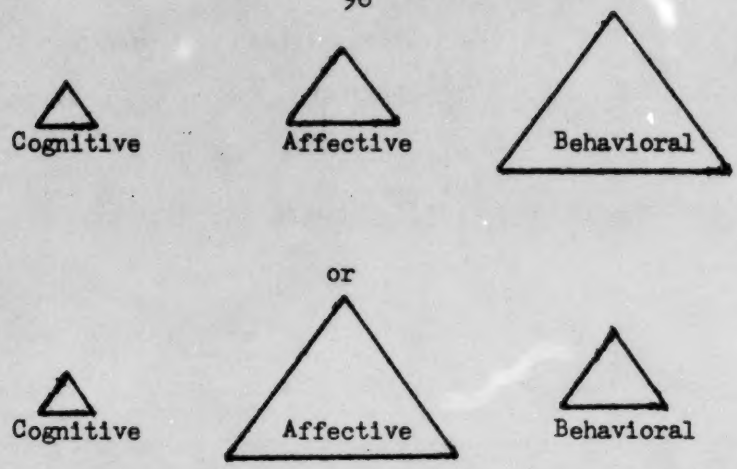
When the cognitive, affective, and behavioral components of personality are in a state of exact correspondence or balance, congruent, a state of positive mental health exists.

Some simple examples of incongruence will help focus the analogy. A hypothetical businessman is heard to say that honesty is the best policy--treat people fairly, and they will reciprocate. In his business dealings, however, he takes every advantage to increase profit, often at the expense of others. His triangles might look like this:



To maintain his stability he would resort to selective perception of his own actions, denial, or rationalization.

Another hypothetical case is the college coed who claims to be liberated from the shackles of her parents' "Victorian value system" and yet lives in very strict accordance with her childhood conditioning or else experiences tremendous guilt for relatively minor infractions.



Therapy, in this latter case, could well be directed at changing her cognitive experience so as to admit considerable constraints from childhood training. It could focus on the emotional discomforts resulting from "transgressions." Her behavior could be the focus of therapy to bring it in line with either or both of the other components. She would be considered to be congruent and adjusted when the three components are balanced; i.e., when she thinks liberation, acts liberated, and feels okay about herself and her actions, or when she acts constrained, realizes the constraints, and accepts with good feelings her condition.

Obviously, the approaches used in therapeutically altering a person's adjustment will have varying effectiveness and results, depending on which component they affect and on which component is incongruent.

Client Styles

The same analogy can be used to illustrate contrasts among clients. Some clients seem to be very much controlled or directed by their cognitive nature. For them, an okay state is synonymous with understanding.

There are two particular concerns relative to dealing with a "thinker." The first is that a method which focuses on cognitive skills will be most readily accepted by the client. To the extent that his/her problem can be resolved through the cognitive access, an intellectual approach will be most effective.

The second concern is an awareness that "thinkers" often ignore feelings. Some are so practiced at ignoring their feeling nature that they are not, cannot, be aware of it. For people like this, whose problem involves lack of feeling integration or is primarily an emotional disturbance, the cognitive access will produce, at best, an awareness or explanation but not a resolution of the problem. For them, the treatment of choice probably would be an affective access, even though it would be difficult.

It should be realized that a simplistic model such as this one is most useful to illustrate and contrast tendencies. The "types" included here are not exclusive or pure, and there are lots of people who fall between types or who seem to be a combination of two or more types.

A second group of clients are those who seem to be led by their emotions. They act or react intuitively and validate their actions relative to how they feel. Many of these people find themselves in long-term difficulty because feelings are present and transitory, working well as guidelines for the present, but not being very reliable relative to the future. The easiest therapeutic access is through the affect; but, as previously discussed, the easiest is not always the best.

The third group, obviously, are the "behavers." People in this group appear to be controlled by external conditions. They do what the

situation demands. To a certain extent it could be said that their lives run them, rather than the other way around. If a person is mis-cued by his environment, the obvious corrective is to re-program the reaction to that cue. For these people, behavioral access is easier and quicker; but, again, caution must be exercised to avoid applying a behavioral cure to an affective or cognitive problem.

There is an apparent overlap or interaction among the three personality components within each person. Sometimes feelings and actions are changed as a result of changing thoughts. Likewise, thoughts and actions may be altered following an affective conversion; and emotional and thought responses may fall into line with behavioral alterations. This is the expectation of some theorists. Albert Ellis says that his form of therapy "... unusually stresses the cognitive aspect of human disturbance, but also importantly deals with its emotive and behavioral aspects" (1969, p. 83).

There is little evidence to support the assertion that the unattended personality components always will come around automatically. A strategy which permits the most direct approach to changing the status of the most incongruent component seems to be a better choice.

Before moving to the dynamics of an integrated model, it should be pointed out that the congruence model is a logical analogy for showing that differences in client styles exist. There are no organized data to support an empirical differentiation of clients to promote access by cognitive, affective, and behavioral means. On the other hand, because empirical research data do not exist does not mean that there is no validity in the model.

Bandler and Grinder (1975, 1976, 1979) have proposed another dimensional system for client types and strategies for communication access. Their system postulates a preference in some people to experience visually, others to favor aural representation of experience, and still for others a kinesthetic or tactile mode. Awareness by therapist and client is enhanced or facilitated when the therapist can identify and employ the client's preferred mode of experiencing.

Some work has been done in contrasting field-dependent and field-independent personalities, with some obvious implications for therapist-client selection (Silverman, 1967).

Suffice it to say for now, the type or style of client is an important variable in therapy which needs to be accounted for in the selection of therapeutic strategy.

Application of Appropriate Intervention Method

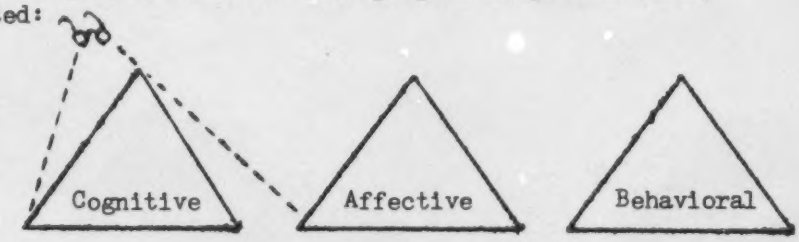
Included in this section are a differentiation of methods by way of the congruence model, a brief description of several specific enhancing skill systems (methods), and some consideration concerning selection of method.

The descriptions of methods are intended to be brief introductions to the method and explanation as to how they fit into a larger, integrated approach. No attempt is made to provide definitive or comprehensive explanations of the methods. The reader is encouraged to seek out and study in depth several representative methods from each section.

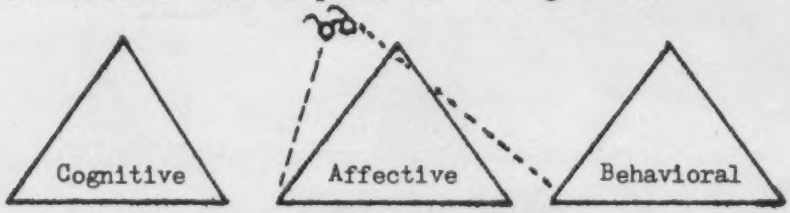
It doesn't take long in the study of any therapeutic method to encounter an attempt to further define that particular method by

contrasting it with others. Implicit in this approach, although not always intentional, is the presumption that this is the better, best, or the only way to be a successful therapist. Such a conclusion usually follows logically from the theorist's premises about the nature of people. Albert Bandura skillfully describes the fallacy of this approach. "What we believe man to be affects which aspects of human functioning we study most. Premises thus delimit research and are, in turn, shaped by it" (1974, p. 859). In generalizing, it could be said that a therapist's beliefs about people limit his approach to intervention, and the results of his attempts to intervene further refine his basic beliefs. This might be graphically shown in the following sequence:

Viewpoint of a theorist who believes people are predominantly thought-directed:



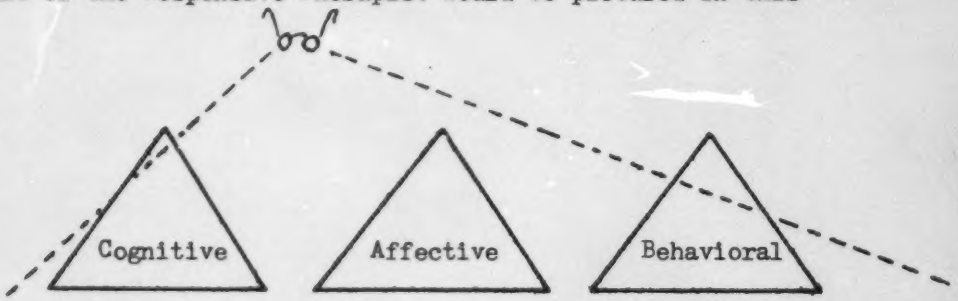
Viewpoint of a theorist who believes that people are directed and most in line with their "flow of potential" through affect:



Viewpoint of a theorist who believes that people are controlled by their environment in some form of stimulus-response contingency:

An eclectic therapist would most likely favor one of the three emphases but select some methodology from the others to "increase" his/her effectiveness.

The preferred stance for therapists, as espoused by this book, is based on the notion that people are either simultaneously cognitive-affective-behavioral creatures, or that there are some clients who will be predominantly cognitive or affective or behavioral, or that people are really a combination of all three but have learned to deal with their reality by habitual reliance on one of the three. This accounts for different styles of people, supports explanations which justify treatment of a client with one particular style by use of an alternate access, and explains why selective, intact approaches are better than eclectic ones. The viewpoint of the Responsive Therapist would be pictured in this way:



This position removes therapists from the difficult position of deciding which of all the theories is "true," but places them in another dilemma; namely, since all are "true" for some people, in order to be consistently effective, therapists must learn many or all approaches.

For the beginning therapist, one training strategy would be to learn thoroughly one theoretical approach from each of the emphases: cognitive, affective, behavioral.

The following sections are intended to give a brief overview of several therapy approaches within each of the emphases. The assignment of approach to emphasis was arbitrary and may be open to challenge in some instances.

Cognitive Methods

This section focuses on several approaches which presume that emotional adjustment, behavioral propriety, and success are achieved as the result of an intellectual or understanding process.

Rational-Emotive Therapy This intervention approach is attributable solely to Albert Ellis, director of the Institute for Advanced Study in Rational Psychotherapy.

The cornerstone is stated succinctly by Epictetus, a Roman philosopher, who said, "People are disturbed not by things, but by the views which they take of them" (advertisement for Institute for Rational Living). Quoting from an advertisement for the Institute for Rational Living,

> Rational-Emotive Therapy (RET) is an action-oriented approach that emphasizes people's responsibility for creating their own upsetting emotions--and hence their unusual capacities to help "recondition" themselves and choose more emotionally satisfying lives.
>
> RET posits that disturbances are chiefly caused by irrational attitudes and beliefs about oneself, others, and the surrounding world. These beliefs and values typically get reinforced during childhood, and are then perpetuated by a process of continuous negative self-reindoctrination. By learning to understand fully, then to actively dispute and uproot their unrealistic shoulds, oughts, and musts, people can develop their capacities for greatly increased self-affirmation, effectiveness, and pleasure.

According to this viewpoint, behavior and emotion are the third step in a values-mediated process. Unlike behaviorists, who would suggest that actions are a result of antecedent or consequent conditions (S-R or S-R-S), RET places emphasis on an intermediate, cognitive step: (A) conditions occur in the environment; (B) the person interprets and judges those conditions; and (C) the person behaves and/or emotes relative to the judgment s/he forms. If the judgment is that conditions are ominous or deplorable, the resultant emotions would be fear or self-pity, and the actions would be flight or "resigned inactivity." If the judgment of the same conditions is that they are challenging and exciting, then markedly different feelings and actions would follow. It is this reasoning, that emotion and action grow out of interpretation, that forms the emphasis on changing the rational interpretations to produce more desirable feelings and acts.

There is a certain style to RET which is best demonstrated by quoting Ellis directly:

> ... most of what we label our "emotional reactions" are caused by our conscious and unconscious evaluations, interpretations, and philosophies. Thus we feel anxious because we strongly convince ourselves that it would be terrible if we failed at something or that we couldn't stand the pain of being rejected; and we feel hostile because we vigorously believe that people who behave unfairly to us absolutely <u>should</u> not be the way they indubitably are and that it is utterly horrible that they are frustrating us. If we more sanely convince ourselves that it is decidedly inconvenient if we fail at something but that such a failure hardly makes us a total loss, we change our feeling of anxiety or depression to one of sorrow without self-deprecation; and if we change our Jehovian hypothesis that people who behave unfairly to us absolutely <u>should</u> not be the way they are to the more empirically-based hypothesis that it would be wonderful if they were not that way but that (a) unfortunately they are and (b) it is clearly frustrating but

> not horrible that execrable behavior like theirs exists, we concomitantly change our feeling of hostility to that of unangry displeasure and a steadfast determination to avoid or to adequately deal with people who behave in this unfair manner (1969, p. 84).

Intervention consists of verbally challenging the "irrationalities" spoken by clients in a strongly confrontive manner. Emotional release frequently occurs as the clients attempt to defend or resist changing their perceptions and evaluations. Under the strong and logical onslaught of the therapist aided by homework and, if group therapy, the pressure of other group members, the client typically relinquishes his prior judgments in favor of those presented to him.

The focus of RET is on the here-and-now, rather than on a historical perspective; it actively hones in on illogical reasoning rather than patiently enduring elaboration and recounting of symptoms; it is quick-tempoed as controlled by the therapist, and is usually limited to half-hour sessions plus homework.

In brief summary, RET is an approach which teaches clients to alter beliefs and judgments from those which result in disintegrative emotions and self-defeating behavior to useful but tolerable emotions and actions which are self-serving and primarily socialized.

Transactional Analysis Many personality theories and therapy models are explained by reference to commonly understood systems of experience. What begins as analogy frequently becomes absorbed into the model by successive refinements of meanings. Such a process is typefied by Eric Berne's development of Transactional Analysis (T.A.).

The basic unit of study is the behavior involved in a dyadic relationship. What one person says to another and its effect in terms of a

reply is analogous to a transaction; the most common meaning for transaction is in commerce where goods or services are negotiated, paid for, and delivered.

Of course even an ordinary business transaction can be very complex, depending on the motives, values, and skills of the participants. It may be fair and honest, or it may involve deception and dishonesty. Success in business transactions requires or at least is greatly enhanced by knowledge, by clear perception of what's being negotiated against an organized residue of similar experience; i.e., conceptual or intellectual skill.

The world of commerce is sometimes called a game, another analogy based on the similarities between some business dealings and the competitive, win-lose nature of games. The winner of the game is the person most shrewd in operating within the rules. The "game" goes beyond a simple transaction where what is purchased is equivalent in value to the price paid for it, a condition in which there are no winners or losers, only mutual participants.

Whenever a player in the game of commerce discovers a technicality or procedure which is not generally known and by which he wins great sums or wins consistently over many transactions, he is said to be operating a racket.

Berne (1961, 1964) and Harris (1967) have established and refined a personal transaction model which on the surface is very similar to the transactions, games, and rackets of commerce. The adoption of familiar language and well-known analogs makes T.A. a deceptively simple and enticing model. It may be this factor which has caused its widespread appeal and popularity.

Underneath the deceptively simple analogy is a fairly well-conceived and rather complete theory of personality development, dynamics, and pathology.

There are two divisions to Berne's model, Transactional Analysis and Structural Analysis (1961). Transactional Analyses focus on an understanding and description of the dynamics of interaction between two people. The motives and style of each participant at any point in time are a result of his or her unique personality, the study of which would be Structural Analysis.

From a philosophy or conceptualization that is so similar to Freudian theorizing to escape comparison, each individual is postulated to be a composite of Child, Parent, and Adult natures or styles. In a transaction, s/he will manifest one or the other of those natures depending on which is executive at that time. Here again is an analogy of a rotating chairmanship. In a very mature and well-functioning individual, the executive power will reside most frequently in the Adult.

Depending on degree of immaturity or pathology, the executive may be drawn somewhat forcefully into the Parent or Child mode (This is referred to as "Hooking the Child.") or may be restrained by or imprisoned within Parent or Child due to boundary sclerosis.

Therapy consists of teaching the person, primarily through intellectual processes involving modeling and verbally educating the Adult mode to maintain executive function, to avoid getting hooked improperly or self-defeatingly, and yet to maintain some spontaniety of Child expression and some tradition and morality of Parent expression.

In brief summary, T.A. focuses on the nature of a person as evidenced by his or her interaction with others and works to correct self-defeating styles (scripts) by altering transactions. The intended progress is from rackets and games (win-lose) to intimacy (win-win).

Bibliotherapy and Cognitive Homework Bibliotherapy is nothing more than augmenting the client-therapist interaction by use of books and articles. It is prescriptive in nature, in that the client is directed to read specific materials at critical times in the therapeutic sequence and for specific reasons.

Biographical treatises may provide a sense of hope and lessening of isolation in the awareness that others have experienced and resolved similar problems.

Humorous or entertaining reading may be prescribed as a contrast or escape from too much mentalizing over problems.

Philosophical or theoretical selections are used to increase the client's understanding of foundation factors, precipitating circumstances, personal or interpersonal dynamics, or processes for remediation of his/her condition.

Cognitive homework may include, but is not limited to, reading. It may include keeping a record of thoughts, experiences, reactions, dreams. Journals and diaries would be included. Engaging in experiences or making observations, recording and analyzing reactions, or self-analysis could be involved.

Bibliotherapy and cognitive homework are typically adjunct to ongoing therapeutic contact between client and therapist. They serve to augment or provide depth or breadth to therapy sessions and to keep the client on task during intervals between sessions.

Brief Therapy An unconventional, but definitely cognitive, model has grown out of contemporary hypnotherapy. Its roots include ideas from early philosophers, Freudian notions of unconscious determinants of behavior, and certain Existential notions of phenomenological living and being in the world. Milton H. Erickson apparently is the primary referent for study, emulation, and focus of theorizing for a number of contemporary proponents of Brief Therapy. This section draws heavily on the works of Paul Watzlawick (1978) and Jay Haley (1973).

Procedurally, Brief Therapy employs a number of techniques geared to by-pass the logically formalized means by which a client "understands" and describes her/his world, and communicates more directly with that part of the mind which is the antecedent for understandings. It is that part of the mind which Freud called unconscious or pre-conscious; it is the "back of the mind" which hypnotists frequently address. Rather than a "lower" part which is below consciousness, or a "back" part which is beyond consciousness, Watzlawick postulates a parallel or "by the side of" mind which is an extremely conscious but generally silent partner to the logical mind. It is silent, by and large, because few people understand how to communicate with it, how to speak its language.

Other forms of therapy are lengthy for two reasons: (1) they first teach the client a new language pertinent to the theory the therapist subscribes to, and (2) they involve long periods of waiting for spontaneous changes to occur. Brief Therapy, in contrast, deals in the language of the "other" mind, and stimulates spontaneous recovery or manipulates the client into self-enhancing activity.

There are two conceptual foundation stones for this model as described by Watzlawick (1978). The first comes from research on brain pathology, most notably that which involves separation of the two cerebral hemispheres. The reactions of patients with commissurotomies have stimulated many postulations of the left-brain, right-brain functions. One such postulation is that "... we have two conscious minds which, ideally, are capable of harmonious, complimentary integration for the purpose of grasping and mastering our inner and outer reality, but which, if and when conflict arises, may be unable to communicate with each other for lack of a common language" Watzlawick, 1978, p. 38).

The lack of common language results from specialization in the left cerebral hemisphere (in right-handed people) for formalized language of reason, science, explanation, and interpretation, while the right hemisphere uses imagery, metaphor, symbolism, synthesis and totality. The right half experiences; the left half explains.

The second foundation stone is the phenomenological assumption, the belief that each individual has a unique experience or perception of reality and that behavior is a product of the meaning attributed to the unique perception.

> Anybody seeking our help...suffers from his <u>image</u> of the world, from the unresolved contradiction between the way things appear to him and the way they <u>should</u> <u>be</u> according to his world image. He then can choose one of two alternatives: he can intervene actively in the course of events and adapt the world more or less to his image; or, where the world cannot be changed, he can adapt his image to the unalterable facts. The first alternative may very well be the object of advice and counselling...whereas the latter is more specifically the task and goal of therapy (Watzlawick, 1978, pp. 40-41).

From the two foundation stones, two conscious minds and perceptual model of world, the basic premise of Brief Therapy can be stated.

> The translation of the perceived reality, this synthesis of our experience of the world into an image, is most probably the function of the right hemisphere. To the left half, presumably, goes the task of rationalizing this image, of separating the whole... into subject and object.... (Watzlawick, 1978, pp. 45-46).

To the extent that the postulated premise is correct, therapeutic change will then occur as a result of three types of intervention: (1) the use of right-hemispheric language patterns; (2) blocking the left hemisphere; (3) making specific behavior prescriptions. The processes of communication through imagery, figurative language, illusions, etc., of confusing the logical mind with paradoxical language, illusion of alternatives, reframing, etc., and of prescribing behavioral tasks which alter the client's pattern of self-defeat, the Brief Therapist promotes spontaneous change.

> Spontaneous change...obviously occurs when certain perceptions or other experiences can no longer be integrated into a person's world image...and thus requires at least a partial change of the image (Watzlawick, 1978, p. 128).

While definitely cognitive in nature, Brief Therapy has a unique set of presuppositions and techniques which require careful study and practice. Proponents claim that it is not necessary to incorporate hypnosis into this model, but there appears to be a decided advantage in doing so.

Affective Methods

The emotional nature and experiences of people can be described as symptoms or outcomes of experiences. They can be seen also as an advanced warning system for avoidance of damaging or life-threatening conditions. They have been postulated as a safety system for expressing or tapping off tension. Some might claim that they form a system, akin to the skeletal system or integumentary system, with a specific life-enhancing purpose. Others would possibly see them as evidence for an integration of mental and physical systems and experiences.

Affective methods give prominence to emotions, either as a system important in its own right or as a significant access to the essence of humanness. They deal with emotions as inner-directed, self-manageable, and accessible only through their owner. Most affective theorists view people as responsible, basically good, and potentially successful. Problems result from environmental circumstances which inhibit natural development or prevent normal emotional expression.

Non-Directive Methods Historically, therapy was seen as a process managed by the therapist and prescriptive in nature. Non-directive philosophy assumes that the experiencing individual is in the best, most authoritative position to know what is happening. If s/he is experiencing dissatisfaction, unhappiness, lack of productivity, etc., it is because s/he has been prevented from developing the willingness to act in his/her own behalf.

An environment which is not threatening and can enhance self-exploration will offer the client an opportunity to find structure to his/her experience, develop strong self-worth feelings, and establish procedures for resolution of her/his problems.

The role of the Non-directive therapist is to create this kind of environment. Carl Rogers (1951, 1961) has been the foremost proponent of this approach. From his experiences and writings have evolved three major characteristics of the therapeutic environment; warmth, empathy, and unconditional positive regard. The techniques of this approach center on non-judgmental reflection of client verbalizations and consistent, patient, long-term support of client self-exploration.

Humanistic Methods The Non-directive Approach, the Existential Therapy (May, 1958), Self-actualization Theory (Maslow, 1954, 1971) and several other views of personkind and therapy have come to be known as the third force (the others are Psychoanalysis and Behaviorism) or Humanistic Psychology. Buhler and Bugenthal provided a brief statement of four qualities of Humanistic Psychology.

> 1. Centering of attention on the experiencing person, and thus a focus on experience as the primary phenomenon in the study of man.
>
> 2. Emphasis on such distinctively human qualities as choice, creativity, valuation, and self-realization, as opposed to thinking about human beings in mechanistic and reductionistic terms.
>
> 3. Allegiance to meaningfulness in the selection of problems for study; opposition to a primary emphasis on objectivity at the expense of significance.
>
> 4. An ultimate concern with and valuing of the dignity and worth of man and an interest in the development of the potential inherent in every person (Sahakian, 1976, pp. 379-380).

Gestalt Therapy Some caution is necessary in properly differentiating Gestalt Therapy from the slightly related, but markedly different, Gestalt School of Psychology.

Around the turn of the century (late 1890s and well into the 1900s), psychology was evolving on several theoretical fronts (Woodworth and Sheehan, 1964). Clinical work was dominated by Freud and Psychoanalysis. "Scientific Psychology" in America was a combination of Behaviorism with its reductionistic preference for isolating deterministic elements of behavior, Structuralism and a similarly reductionistic quest for the elements of experience, and Functionalism with its focus on specifics of application. Gestalt Psychology grew largely from European Philosophy, mostly Germanic, and existed strongly as an anti-reductionistic force; the dictum, "The whole is greater than the sum of its parts" reflects the Gestalt belief in the imbeddedness of behavior and effects of surroundings or context on the "figure" or focus of study. Early Gestalt psychologists were very much into the study of perception.

Modern day Gestalt Therapy was popularized by Frederick Perls (1969). Its similarity to the earlier Gestalt Psychology is superficial but probably worth describing. Both took a lot of initial definition and popularity as a reaction against Behaviorism and behavioristic methods; both have an emphasis on perception, the school focusing primarily on perceptual processing of visual inputs and insight as a process of perceptual sorting, and the therapy emphasizing awareness of conditions primarily kinesthetic and imaginal; the School could be said to focus on space outside the body; the therapy is concerned with inner space. Both attracted many disciples and, in the case of Gestalt Therapy, their fervor caused them to label many techniques as Gestalt which historically preceded the movement (see Passons, 1975).

Modern day Gestalt Therapy fits well within the broader rubric of Humanistic Psychology. It postulates an innate striving on the part of humans, plants, and animals toward self-actualization (Perls, 1969). There is, however, no universal hierarchy of needs so that individuals influence their own status in unique ways. An individual is not separate from his/her environment, and thus is a participant in an ongoing flow of dynamic forces. Actualization is a process of "going with the flow," willingly because of a global awareness of the forces in the flow and the individual's relationship to it. Gestalt Therapy is a means for establishing awareness of the flow and reducing or eliminating feelings or behavior which inhibit or go counter to the flow.

Gestalt techniques incorporate a lot of communication skills, awareness focus skills (here and now, you and I), self-responsibility emphases ("I messages") which are common to a large number of contemporary models.

There are some things which seem unique to Gestalt Therapy. These include projection of self into objects or other people or parts of experience, dialogues within self--as in, "What is your stomach telling you?"--and enactments of bipolarities such as the neat and tidy versus sloppy parts of our personality or the kind and considerate versus selfish and insensitive parts. Through use of such techniques, both personal and environmental factors which are influential, but largely unnoticed, are brought into focus (figure) for analysis; and a more fluid movement of factors from context (ground) to focus (figure) provides increased awareness and ability to know the flow and be an active participant, an integrated personality.

Body Therapies All theory has roots firmly planted in philosophy and is based logically on premises growing out of that philosophical foundation. Validation is usually a circular process and can be seen quite clearly in the body therapies.

For centuries people have debated the basic nature of humanity. Are body and mind or body and soul two separate and distinct entities (dualism)? Is there an integrated, single characteristic which incorporates all facets of life (monism)?

If the presumption is dualism, then separate treatments are in order for body ailments and mind disorders. The history of physical medicine and mental illness is strongly influenced by a dualistic philosophy. Attribution of mental illness to evil spirits or the muses, and even to gifts from God made it totally separate and distinct from physical concerns (Menninger, et.al., 1963). To follow up on the notion of circular validation, if treatments designed to alter the body are successful, then direct intervention into the troubled system is the treatment of choice and requires no concern for separate systems.

If the presumption is monism, then any type of therapeutic intervention will affect the entire system. It would be possible to effect positive emotional state by establishing a healthy physical condition; good mental status would similarly enhance physical functioning. Conversely, mental stresses would be seen as causal factors in physical disease and physical deterioration or disease would produce negative mental or emotional conditions. Psychosomatic medicine and the Holistic Health Movement are based on the monistic tradition. Circular validation of the monistic premise would occur when treatment modalities based on it

produced total system changes, or when psychotherapy produced physical improvement and when medical treatment removed emotional symptoms.

The body therapies are based largely on the notion that body segments or body systems, mostly the integumentary and musculature systems, are repositories of the effects of emotional conditions; i.e., people store the residue of tension in their muscles. This being the case, it is then possible to act directly on those systems to loosen up the tensions and permit the body to return to normal functioning.

One of the early body therapists, Wilhelm Reich, believed that there are seven regions of the body, which he called rings of armoring, that must be progressively broken to free the person from residual tensions. Lowen and his Bioenergetics (1975) and Rolf with her Rolfing (1975) are contemporary practitioners who have established systems of direct body manipulation by the therapist to aid in the removal of mental or emotional maladies.

Provocative Therapy Based similarly on the notion that emotions get stored up or blocked in people who have emotional illness is a system for eliciting expression of those emotions. Farrelly and Brandsma (1974) have pioneered what they call Provocative Therapy. This approach can be summarized as an attempt to cause the client to martial his emotional resources in defense of himself against the barrage of

badgering, belittling and insulting verbalizations of the therapist. This is seen by many therapists as a highly specific, "narrow band" technique to be used selectively on a few clients. Farrelly and Brandsma profess success in a number of conditions and for a variety of clients.

Behavioral: Symptom Control Methods

Based on the assumption that there is no deep-seated personality disturbance that causes problematic or self-defeating actions, the behaviorist proceeds to alter directly the symptoms of distress. Quite simply, the symptom is the disorder. The following are three models for symptom removal, alteration, or control.

Behavior Modification This approach is simply an application of operant techniques devised by B.F. Skinner and tested thoroughly on rats and other sub-human species. Control of behavior happens as a result of environmental dynamics which become learned as signals and outcomes related to specific behavior. When a response is made by a person in a circumstance which has perceptable characteristics and a change in condition occurs which increases the probability of that same (or very similar) behavior occurring in the same (or very similar) circumstance, behavior has been modified.

Repetition of a behavior which results in absolutely no change of condition generally results in cessation of that behavior. This is the extinction process.

Application of behavior modification is concerned with either the process of establishing an absent but desirable response, removing a present and undesirable response, or both.

The procedure follows, in some form, these basic steps:

1. identify the target behavior.
2. measure or systematically count occurrences of that behavior.
3. determine what consequences are currently supporting the continuation of an undesirable behavior or what outcomes, if added following a desirable behavior, will increase its probability of recurrence.
4. cause the person to exhibit
   a. undesirable behavior in the absence of its reinforcer, hence extinguishing it, or
   b. desirable behavior with the consequence of an outcome which increases its tendency to recur.
5. measure target behavior again to see if the expected changes have occurred.

Behavior modification techniques are especially applicable to environmentally cued habits; some examples are: overeating, smoking, poor concentration, and language difficulties.

Contingency Management The theoretical basis for contingency management and behavior modification are identical. The primary distinction, which is not uniformly made by all practitioners, is that behavior modification is applied to a single client in a therapeutic setting whereas contingency management is creating and maintaining a system for groups of people or for individuals in a group setting.

Precision teaching, Premack Principle, Token Economy, Programmed Learning, Computer-assisted Instruction, Behavior Contracting, all are applications of contingency management.

The basic procedures include:

1. defining the desired terminal behavior.
2. establishing reinforcers, usually more than one so as to account for differences in individual preference, which are to be given contiguously or nearly so to acceptable approximations of the desired behavior.
3. a system for continuous monitoring and application of the reinforcers.

While both contingency management and behavior modification appear to involve artificial manipulation of clients through application of extrinsic rewards, a rather convincing case can be made for its near parallel to "Mother Nature's" methods and her intrinsic outcomes.

Structural Family Therapy During the 1950's, several therapists began the process of shifting focus from the individual as client to dealing with identifiable systems or social contexts. The family became identified as a system which functions or malfunctions with symptomatic import on its members (Haley, 1971). The initial movement was simply a change of definition of client from individual to family, and involved relatively little change in theoretical or procedural approach; i.e., each therapist employed his/her preferred techniques within the appropriate theoretical context. One method which has evolved as uniquely a family or family system approach is Structural Family Therapy.

Perhaps the foremost proponent of this approach is Salvador Minuchin. He defines Structural Family Therapy as "... a body of theory and techniques that approaches the individual in his social context. Therapy based on this framework is directed toward changing the organization of the family" (1974, p. 2).

In Minuchin's description of three "axioms" of his approach, there is a distinct flavor of reciprocal determinism ala Bandura (1978);

however, descriptions of therapeutic intervention appear to be directed at changing the social-environmental field in order to alter the balance of forces acting upon the individual, thus causing her/him to behave differently. This is similar in some respects to Lewinian Field Theory (Cartwright, 1951).

The three "axioms" are:

> 1. ...an individual's psychic life is not entirely an internal process. The individual influences his context and is influenced by it in constantly recurring sequences of interaction. The individual who lives within a family is a member of a social system to which he must adapt. His actions are governed by the characteristics of the system, and these characteristics include the effects of his own past actions. The individual responds to stresses in other parts of the system, to which he adapts; and he may contribute significantly to stressing other members of the system. The individual can be approached as a subsystem, or part, of the system, but the whole must be taken into account.
>
> 2. ...changes in a family structure contribute to changes in the behavior and the inner psychic processes of the members of that system.
>
> 3. ...when a therapist works with a patient or a patient family, his behavior becomes part of the context. Therapist and family join to form a new, therapeutic system, and that system then governs the behavior of its members (Minuchin, 1974, p. 9).

A picture is presented of a family system, a sort of homeostatic entity wherein change in one part causes changes in other parts. The system seems to transcend its members. A healthy system is one which is flexible enough to adjust to member variations. "Responding to ... demands from both within and without requires a constant transformation of the position of family members in relation to one another, so they can grow while the family system maintains continuity" (Minuchin, 1974, p. 60).

Pathology occurs when the ability to be flexible is absent and instead the family reacts to stress by increasing the rigidity of its transactional patterns.

The task of the therapist is to enter the system, diagnose the functionally rigid portions, institute appropriate adjustments, and then exit the system, leaving it to function autonomously. This is somewhat analogous to a mechanic who trouble-shoots out the malfunction, adjusts the critical parts, and then leaves it alone until some future breakdown. Much as with the automobile, the critical component in the malfunction is not always the one which shows the symptom.

"Change is seen as occurring through the process of the therapist's affiliation with the family and his restructuring of the family in a carefully planned way, so as to transform dysfunctional transactional patterns" (Minuchin, 1974, p. 91).

Because therapeutic change in an individual occurs through intervention in the system, and his function is dependent upon the system, this model fits quite nicely into an environmentally determined, stimulus control framework.

Reciprocal Inhibition Of several applications of Pavlov's work, later dubbed classical conditioning, the most refined and presently used system is that of Wolpe (1973). The basic notion is that emotional response is the result of the contiguous linking of a strongly obvious environmental condition and viscerogenic or autonomic reactions. These emotional learnings are possibly useful or, at worst, harmless in their normal manifestations; however, when abnormal as in phobias or high anxiety states, they are very self-defeating.

The opposite of a high-arousal, high emotional state is deep relaxation. Wolpe postulated that if the inappropriate emotional response were a result of improper learning, then a more useful response could be conditioned into the person which would compete with, or inhibit the maladaptive one; hence reciprocal (opposite to maladaptive) inhibition (prevention of responding).

Procedurally the client is first instructed in methods of deep relaxation. S/he is then put through a series of vicarious experiences which gradually, so as not to upset the relaxed state, approximate the high anxiety or phobic situation. Once the client can experience the signals for emotional upset and at the same time respond with relaxation, his/her newly learned response set overpowers or inhibits the earlier, problematic response.

Behavioral: Social Skills Methods

This section includes the term "behavioral" because the methods are directed toward producing changes in observable behavior. It draws heavily on the works of Bandura (1969, 1974, 1978), Glasser (1965), and Bandler and Grinder (1975, 1976, 1979), none of whom are theoretically aligned with behaviorists of the operant conditioning variety.

Both Bandura and Glasser see the individual as an active, potentially responsible participant in her/his cognitively mediated responses. Both accept the importance of environmental conditions as influences in behavior. Bandler and Grinder place the problem as improper links between deep structure (unverbalized determinants) and language as a control model.

Vicarious Reinforcement One means for altering the behavior of a client is to show him examples--pictures, movies, videotapes, live models--of people engaging in desirable behavior and receiving positive returns for their behavior. Much of modern movie and television fare relies upon the viewer to identify with the person of focus (hero, victim, anti-hero) and vicariously share his/her plight and outcome. Advertisements are replete with suggestions, both overt and covert, that paying for and using a product will produce for the consumer the same, or very similar results as they presumably did for the advertisement model.

As therapists, it is possible to use imaginary or representational people as tools to influence change on the part of clients.

Modeling Related to, and a part of, vicarious reinforcement is modeling. It is treated separately to focus on the effectiveness of using a model to demonstrate alternative behavior strategies to clients without drawing attention to an obvious reinforcement. The therapist who deals calmly with the client's crisis is modeling an alternative response to his/her client and tacitly giving permission for the client to do likewise. Identification with or problems in identifying with exemplary models in the client's social environment provides input for problem analysis and/or resolution strategies.

Reality Therapy This approach, popularized by William Glasser, might well be called a cognitively mediated behavior modification approach. While the outcomes of a person's behavior occur in a social context and operate somewhat predictively, the client needs to learn that proper management of "reality, responsibility, and right-and-wrong" will produce more consistently desirable outcomes.

That the focus is on change of behavior is demonstrated in the foreword of Glasser's book where it says, "... human beings get into emotional binds, not because their standards are too high, but because their performance has been, and is, too low" (1965, p. xiii).

In its original form, Reality Therapy was applied to incarcerated juveniles. The procedure, tersely stated, was to produce a simplified environment where the relationship between behavior and outcome could be readily apparent and constant. The inmate soon gained the insight that the outcome for herself was under her control; she found that she was responsible.

In clinical application, effort is made to help the client see the relationship between his/her behavior and to learn alternative actions. Some attempt to modify the environment may occur, but the major impetus is toward creating in the client an awareness of self-responsibility. Part of this process is for the therapist to avoid taking any responsibility for the condition and outcome, and to refuse to acknowledge any outside responsibility.

Neuro Linguistic Programming This particular model is difficult to place neatly in the categories. It contains some reference to cognitive function (language as a Meta-model); there is a gestalt or integrational flavor (seeing, hearing, feeling as routes to experience); and there is a classical conditioning emphasis (stimulus substitution and signal learning). Because the favored intervention seems to be a reconditioning or reprogramming, the model is placed in the behavioral section. Because the reprogramming is done with unverbalized or pre-

cognitive aspects of the personality and is, hence, similar in some respect to vicarious conditioning, it is placed in the section with Bandura and Glasser.

Problems of adjustment or incidents of self-defeating behavior occur as a result of the way people learn to explain their reality. In essence, they build a language theory or model of reality and then work from the model rather than from the reality upon which it is based.

In the process of model building, most people adopt a preference for seeing (visualizing), hearing, or feeling as a means of access to the world. Their chosen modality tends to dominate the "program" upon which they operate.

The goal of the NLP therapist is to increase options, hence variability, for the client so that s/he can avoid self-defeat. Access to the client's process style is achieved by discovering the preferred mode of experiencing. Through appeals to that mode, or through a variety of techniques to by-pass it, a new program is established which includes the old choices as well as a number of alternate ones.

The solution of problems is not in the identification of preferred experiential mode, nor is it in the integration of the three modes. The modes simply provide access to the deeper structure where classical conditioning processes called anchoring, bridging, and changing history are performed.

Anchoring is the process of associating a condition or attitude with a therapist-controlled stimulus (stimulus substitution) such as a touch on one shoulder, a word, or an eye fixation. Subsequently the new stimulus can be used to elicit the condition or attitude.

Usually an alternate program (behavior, belief, attitude) is vicariously established and anchored to a similar stimulus; e.g., a touch on the other shoulder.

Bridging occurs as a result of stimulating both anchors simultaneously and/or by ritualistically combining vicarious ways of coping (visualizations, or auditory, or kinesthetic hallucinations). The result is an "integrated" program which allows either previous choice or selective modifications or combinations.

Changing history is a process of anchoring the memory of some aspect of personal history (which is often not factual) and bridging that anchored memory to a more acceptable, created memory. Reality is not changed, but the model--which determines behavior and satisfaction--is altered in such a way as to provide more choice and more control to the client.

A key concept in NLP is process. The content of verbalizations is not significant except as a clue to referential modes and since eye motions or other cues are available to identify process, it is possible to produce therapeutic change without knowing a verbal description of the problem.

While Bandler and Grinder claim that it is not necessary to know hypnosis in order to do NLP therapy, their background and many of the philosophical underpinnings of the model suggest that such knowledge would be very advantageous to anyone adopting this approach.

One additional characteristic of NLP therapy is variability in modifications of therapy. If something does not work, the problem is

assigned to the therapy and not to the client. "If what you are doing is not working, change it. Do something else" (Bandler and Grinder, 1979, p. 73).

As a brief comparative digression, it appears that a major contrast between NLP and Social Learning is that the NLP therapist behaves like the client (mirrors) in order to understand and expand options from within. The Social Learning therapist presents examples (models) for the client to approximate as a means of increasing options from without. It may be that mirroring and modeling are two sides of the same coin.

Selection of Method

The previous descriptions of methods comprise a very brief overview. Quite obviously, people choosing to use any of them should become thoroughly educated in their underlying philosophies, techniques, and appropriate applications. It is not helpful, and probably damaging, to employ techniques indiscriminately and without sound preparation.

Assuming proper preparation in several treatment methods and sufficient knowledge of others to afford sensible referral, the next problem is in determining which method to employ or to which therapist a referral should be made.

The early phases of therapy, managed by use of the SITE skills, enables the therapist to reconstruct major elements of the client's phenomenological space and to monitor ways in which the client has attempted to manage his/her world. The client styles related to understanding, feeling okay, and outcome control as described in the section dealing with cognitive, affective, and behavioral modes of preference provide a framework for describing the ways the client has tried unsuccessfully to cope with problems.

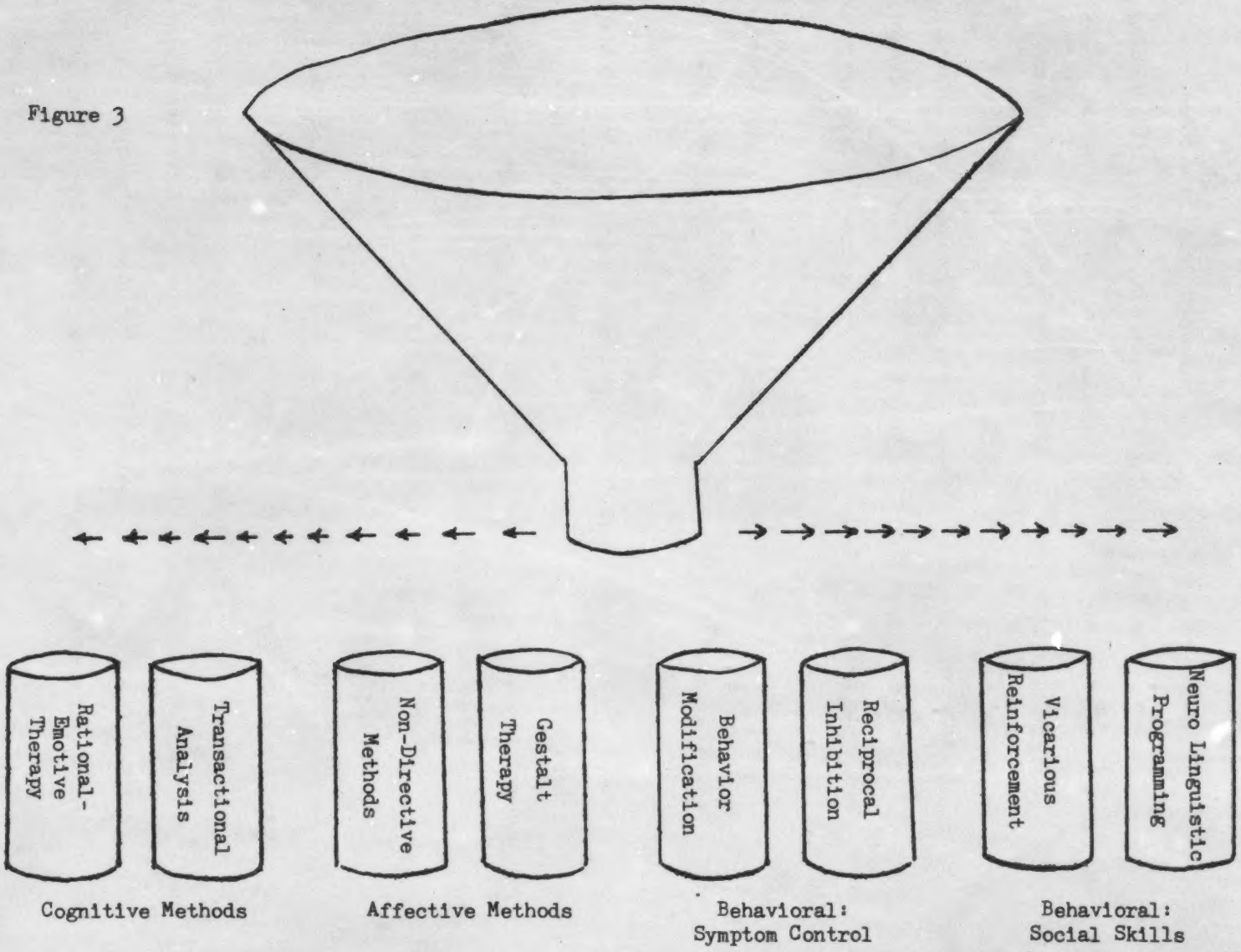
A problem is basically nothing more than a condition which needs to be changed, possessed by a person who does not know how to change it. This lack of knowledge may be categorized as presence of self-defeating behavior or attitudes, lack of awareness or understanding, and lack of requisite skills.

The appropriate therapeutic method to be applied from the narrow band, specific enhancing skill category is that one (or those) which most efficiently removes the behavioral or attitudinal block or which provides the necessary awareness or skill. Once again, it is important to point out that the therapy of choice often may counter the client's preferred style because of his/her over-reliance on that preferred style.

Figure 3 illustrates the dynamics of moving through the funnel to identify the critical factors, styles, and problems and then "dumping" them into the appropriate methodological receptacle. Please note that the receptacles are discrete, mutually exclusive, theory-pure methods. It is common for different problems within the same client system to be treated by different, but selectively appropriate methods within the same time frame. As Cormier and Cormier point out,

> A variety of strategies is necessary in order to treat the complexity and range of problems presented by a single client. It is just not that common to encounter a client with only one very straightforward concern (such as fear of flying in airplanes) that can be treated successfully with only one strategy (such as systematic desensitization) (1979, p. 255).

Figure 3


Rational-Emotive Therapy
Transactional Analysis
Non-Directive Methods
Gestalt Therapy
Behavior Modification
Reciprocal Inhibition
Vicarious Reinforcement
Neuro Linguistic Programming
Cognitive Methods
Affective Methods
Behavioral: Symptom Control
Behavioral: Social Skills

Summary

Therapy proceeds in an orderly manner through initiation, tracking, and general enhancing to arrive at an awareness of specific problems and client styles. At this point, the selection of appropriate methods or process enhancers specific to the client's needs and style can be made.

Internal congruence, or a balancing of the cognitive, affective, and behavioral components of personality is a common goal of therapy. Unresolved problems are accompanied by an imbalance in these components or a state of internal incongruence.

Clients vary in their reliance on or preference in working with one of the personality components, sometimes to the exclusion of the other two. People can be seen to treat understanding as the means to all problem resolution; others validate success by how they feel; and still others operate very much as though they are controlled by external conditions and factors. Obviously, not all people fit neatly into one of the three categories.

Probably growing out of the therapists' preferred modes or styles or from the tendency for certain types of clients to congregate at hospitals, clinics, schools, jails, or other therapeutic settings, the various counseling or therapy methods reflect stylistic patterns which tend to fit certain clients or conditions while not working with others.

Methods can be grouped according to their stylistic techniques and underlying philosophies. One such grouping consists of four categories: cognitive methods, affective methods, behavioral: symptom control methods, and behavioral: social skills methods.

Rather than narrowly specializing in one method or even in one category, students of therapy are advised to know thoroughly at least one method from each of the categories and to be acquainted with many others. They are also advised to employ their chosen methods in a theory-pure manner sensitively matched to the client problem and style for which it is the most appropriate method.

Chapter VI THEORY BASE, AN INTEGRATIVE APPROACH

> Everything a teacher does is colored by the psychological theory he holds. Consequently, a teacher who does not make use of a systematic body of theory in his day-by-day decisions is behaving blindly (Bigge, 1976, p. 6).

Presuming truth in the above statement, a truly professional helper must either align closely with an existing theory or crystalize and explicate his/her own.

Based on the desire to be truly professional and in an attempt to be thorough, this chapter will explain the experiential, philosophical, and theoretical bases which undergird Responsive Therapy.

The first section provides an autobiographical account of the evolution of attitudes and concepts important in the formulation of this method.

Next, the chapter will include a section of philosophical assumptions which form the premises from which the theory should logically flow.

Finally, the theoretical model for Responsive Therapy will be described in detail.

Background

The process of studying to become a therapist has been a complicated and haphazard process. The particular outcome of such study was predicated upon the style or type of therapy in vogue at the time or espoused by the training institution. Not having much experience to draw upon, and with no systematic survey of possibilities or integrated base for a beginning, the student was limited to pursuing a discipleship determined by his/her choice or by whatever factors were active in getting into a training institution.

Many students have been faced with some professional existential crises when their limited experience or unique personal style inclined them toward ideas or strategies foreign or antagonistic to that of their teachers. Some of my experience illustrates this well. While the theorists and ideas may be typical to the age and time of training, the dynamics are very much the same for all of us.

Parenthetically it should be stated that because what is to be explained is an evolution of a personal theoretical position, it is written in the familiar, first-person singular form.

As a student in the fifties, I was swept along in the non-directive, Rogerian tide. I was thoroughly steeped in the philosophical assumption that each person has worth and dignity and that each person has the capacity for self-direction and self-actualization. The logical method of presenting an environment which is optimal for personal growth and which is marked by warmth, empathy, and unconditional positive regard (love) was readily accepted. Subsequent reading of Rousseau led me to realize that the philosophical roots of a facilitative method were, indeed, old ones. That growth or progress is the responsibility and option of the client was communicated in ideas such as, "Progress comes through the thinking that the individual with a problem does for himself rather than through solutions suggested by the counselor. The counselor's function is to make that kind of thinking possible rather than do it himself" (Tyler, 1953, p. 14). The strong analogy of preparing a growth environment in counseling and the soil preparation and plant fertilization of agriculture for facilitating optimal growth occurred to me, and at first was reinforcing to the notion of preserving or enhancing the

natural order of things. Then the awareness of gains in agriculture happening as the result of hybridization and other forms of direct intervention caused some turmoil.

In my naivete, I assumed that Rogers and that my professors were disseminating "Truth." Some inconsistencies in the training program and contact with other disseminators of different "Truth" created a fair amount of cognitive dissonance. Here are several examples of dissonance producing elements:

1. I was subject to some rigorous training in the use of statistical method and psychometrics. Rogers de-emphasized or even belittled the use of testing in therapy. If it was neither necessary nor advisable, why did "they" prescribe it for my training?
2. Freud, historically of some significance in the evolution of therapy, spent lots of time regressing his patients to earlier experiences, probed the unconscious for primitive, unsocialized motivations, and worked to balance deterministic forces which were outside of patient awareness. Rogers put a premium on the present and avoided probing.
3. Jung took issue with Freud on several counts and with both Freud and Rogers on the degree of therapist involvement. Jung, "... does not analyze an object at a theoretical distance but is quite as much in the analysis as the patient" (Jacobi, 1954, p. 89). A definition of therapy which, in my memory, is attributed to Jung was that therapy is an experience between two people for the express purpose of change in one of them, hopefully the client.

4. Adler, another one-time disciple of Freud, took issue with Freud's amphasis on unconscious determinants of behavior.

> He stressed the need of studying the total personality as a dynamic and indivisible unity in respect to all the manifestations of behavior, and furthermore, in intimate positive interrelation with the social setting, more particularly the immediate social background represented by family and other direct associates (Karpf, 1953, p. 42).

5. Rank regarded the patient as self-reliant and self-responsible. "... the individual does not merely adapt himself passively to his environment; he also controls, directs, and moulds it" (Karpf, 1953, p. 54). This sounds very similar to Bandura's description of reciprocal determinism (1978). In fact, after much additional study, I find that most of the principles which were advanced as "Truths" by the therapy masters were, in some form, described previously and have been restated subsequently by more contemporary theorists.

6. Other sources of dissonance for me were E.G. Williamson (1939), and F.C. Thorne (1950).

Obviously there were differences of opinion (no longer "Truth") among the various theorists as to what were (1) the sources of patient/client maladjustment, (2) the dynamics of personality integration, and (3) the appropriate techniques of therapy. While much can be said or done to discount particular theorists in light of "new" discoveries or in relation to what approach presently is fashionable, the dynamics of reasoned disagreement relative to who is correct still persist.

For me, as a student in the fifties, it was not possible to discount all of the dissonance, so I took a somewhat defensive approach and

slipped into a personalized eclecticism. This position was formalized in this list of eleven propositions which I could accept.

1. The client is the focus of counseling. Counselor needs should be minimized.

2. Each personality works as a unit and shouldn't be segmented for treatment. It is also unique and dynamic.

3. The client is inherently responsible and capable of taking care of himself, provided sufficient education for problem solving has occurred.

4. The counseling situation is primarily one of education.

5. The counselor is concerned with the present; i.e., with the person as he presently sees himself.

6. Educational materials, including tests, are an indispensable part of successful counseling.

7. Physiological factors can be very important to successful counseling.

8. Because the counselor is seen as an authority figure, he can probe when it will advance understanding.

9. Formal diagnosis may be useful in serious deviation but can't be separated from treatment in the counseling situation. There is some diagnosis in every method, but it should be de-emphasized as much as possible.

10. It would be foolish to suppose the counselor can avoid influencing the situation. A certain amount of value imposition seems unavoidable, but isn't serious if it is recognized ... .

11. The method involves a maximum of reflection of feelings with an occasional clarification or shallow interpretation... (Gerber, 1961, pp. 8-9).

While this was not well-refined and shows an appropriate immaturity, it demonstrates both the dynamics of falling into an eclectic style and the weaknesses and inconsistencies of such an approach.

Following my Rogerian period, I developed an interest in existentialism, and Rollo May became a model for me. This was, in retrospect, a time of introspection and value testing for me. After reading May, et.al. (1958), Barrett (1958), Brown's treatment of Kierkegaard, Heidegger, Buber, and Barth (1955), Kaufmann's edition of existentialists (1956), Barrett's work on Zen Buddhism (1956), and Max Otto's essay on science and the moral life (1949), I was again in a position of cognitive dissonance. This time it was the problem of trying to incorporate some new learnings in philosophy with a background and indoctrination in a rather fundamentalistic Christian tradition. Again I came up with a statement of tenets with which I could live.

1. Each person is unique and should be allowed the opportunity to express his individuality.

2. Each individual is responsible for his actions.

3. People are basically me-centered.

4. The focus of existence is the Mitwelt and success in this depends on learning to exist on the Eigenwelt level.

5. One cannot, even in the Eigenwelt, exist in the absence of people. He needs a certain amount of social feedback against which to evaluate his position.

6. In relation to the reactionary position of Existentialism, I find myself in a position of dialectic reasoning; (a) while I strongly favor a wholistic, humanistic conception of man, I still find abstraction and time control...to be a useful tool in better understanding man; (b) while I am strongly attracted to the idea of looking at man monistically, I find the dualistic tradition an undeniable part of me; I can resolve this to an extent by looking at traits, behavior, etc. as falling on a continuum, thus avoiding rigid dualism; (c) I tend to accept the emphasis on free will or individual control but realistically must accept certain manifestations of materialism and conformism ... and, to an extent, the fact that

present and future actions are affected (but not completely determined) by the past; and (d) I share the position of saying much is lost in segmenting personality, but I (believe) that (measurements) taken through segmenting can aid in understanding the study of the complete, functioning personality.

7. Man is engaged in a continual process of becoming, therefore, one must emphasize enjoyment of the process.

8. The individual determines the direction his process should take.

9. Man may choose to avoid responsibility for this determination by borrowing the values of someone else or by conforming to societal or religious systems.

10. Man is basically social and, if given the opportunity to choose, will choose socially constructive alternatives.

11. To have a choice, one must have the opportunity to make the "wrong" choice.

12. There is an interaction between past, present, and future in which any one can influence activity in both of the others (Gerber, 1962, pp. 6-7).

Although time and experience would cause me to modify or restate some of the principles, the awareness that my behavior, particularly as a therapist, is an outgrowth of my philosophical assumptions still burns strongly. If that is true for me, it must be true for other people even though neither that fact nor the philosophical assumptions are always stated by proponents of the various approaches to therapy.

That the field of counseling and therapy is very dynamic with much variation or diversity is obvious from a survey of various methods which have gained prominence in the past twenty years. The list would include models such as:

Reality Therapy	Bioenergetics
Transactional Analysis	T-Groups
Adlerian Family Therapy	Encounter Groups
Behavior Modification	Marathons
Reciprocal Inhibition	Computerized Counseling
Humanistic Methods	Neuro Linguistic Programming
Primal Therapy	Brief Therapy
Biofeedback	Structural Family Therapy

There are few "old timers" and many pioneers in the helping professions.

Add to this diversity the various models or theories of learning, personality, growth and development. The following sections are an attempt to draw together the many diverse elements into a theoretical mosaic. They are my attempt to make non-eclectic sense out of a myriad of dissonant experiences in learning, teaching, and using variant theories from each of the areas of learning, personality, growth and development, counseling or therapy and mental health.

Assumptions

> ... every scientific method rests upon philosophical presuppositions. These presuppositions determine not only how much reality the observer with this particular method can see--they are indeed the spectacles through which he perceives--but also whether or not what is observed is pertinent to real problems and therefore whether the scientific work will endure. It is a gross, albeit common, error to assume naively that one can observe facts best if he avoids all preoccupation with philosophical assumptions. All he does, then, is mirror uncritically the particular parochial doctrines of his own limited culture (May, et.al., 1958, p. 8).

Since the primary point of vulnerability in many contemporary models lies, not in their logic, but rather, in their premises, this section is an attempt to state the philosophical presuppositions of Responsive Therapy. Their validity may be ultimately demonstrated in practice; however, now they are subject to the reader's analysis, comparison, and evaluation.

Assumptions about people:

1. People are basically good. Good people can and occasionally do behave badly.
2. Individuals have the opportunity for choice; i.e., relative free will. They do not often realize or use that opportunity.
3. Maturity consists of the ability to
   a. obtain objective perceptions of self and of reality.
   b. make clear, decisive commitments.
   c. demonstrate self-responsibility for choices.
4. Negative forces, evil, sin are conditions, occurrences, or behavior which restrict attainment and practice of self-knowledge, self-choice, and self-responsibility.
5. Most personal problems are self-induced and are self-defeating. They arise from clouded perception, improper conditioning, or irresponsibility and result in poor (i.e., stupid) choices.
6. The physical, social, and emotional "worlds" operate lawfully, hence predictably. Free choice requires knowledge of the limitations set by law.
7. People make the best adjustment possible within their perceptual set (ala Menninger, et.al., 1963); therefore, therapy for maladaptive adjustment is a form of education for more accurate, objective perceptions of reality (ala Seligman, 1975), for more numerous potential alternatives, or for skills in managing the process of self-responsibility.

Assumptions about theory:

1. Existing theories are reports based on empirical, behavioral referents; therefore, all contain some "truth" as a model or construct of how things really are.
2. Differences among theories are a result of
   a. sampling error. Not all theorists view the same subjects under the same conditions, yet most theorists generalize quite freely to all people.
   b. the model used to explain the observations. While the empirical referents might be described clearly, the explanations of dynamics and relationships are subject to all of the frailties of communication.
   c. successive observations being colored or distorted as a result of early formulations of the model; i.e., perceptual bias and selectivity.
3. Life cannot be described by either pole of a dichotomy (e.g., objective-subjective, behavioristic-gestalt, etc.) nor can it be explained by one dichotomy and a continuum between extremes; however, to the extent that each model represents truth, it must be included in a more complex description of reality.
4. Models representing growth, development, and learning have one commonality; they explain progress. Models of adjustment, mental health, mental illness, physical health, and physical illness describe facilitative and inhibitive qualities or conditions which affect that progress.

The form of reasoning or attitude that only one theory or position can be true or best forces us into acting as though reality exists in polar extremes, in dichotomies. For example, a well-worn issue in philosophy is whether people exist as free beings or as determined entities, free-will or external determinism. To believe one is to disclaim the other.

A common resolution from the bind of simple dichotomy is to assume a continuum between the extremes. People are neither totally free nor totally determined. They exist somewhere between the two poles. This is a resolution by dialectic reasoning where an extreme statement (thesis) is compared to its opposite extreme (antithesis) with the expectation of obtaining a more accurate view of an intermediate reality (synthesis). Eclectic models of therapy are synthetic.

Consider another, not so common, viewpoint. People exist at both extremes and all along the continuum between poles. Some people behave as though they are entirely determined by outside forces, or many people at some time or under some circumstance appear to be determined; some people demonstrate a remarkable degree of self-determination; some people show a mixture of external and self-determination or an alternation between the two. The most appropriate therapeutic techniques will be those most nearly matched to the type of person or style of behavior.

Responsive Therapy is based on the latter viewpoint. It is an attempt to integrate, somewhat intact, the various and diverse therapeutic models into one system.

Responsive Therapy, an Integrative Model

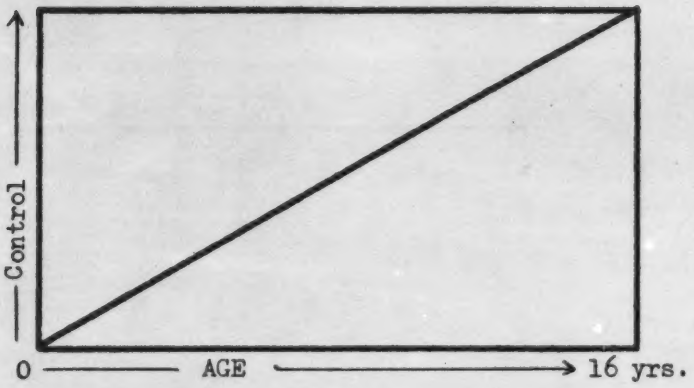
The basic structure for the Responsive Therapy model is a modification of maturational control rectangle (see figure 4). The maturational control rectangle was encountered by the author over twenty years ago in an old, obscure book, the reference to which has since been lost. It states that people have a potential amount of control over themselves ranging from none at birth, to 100% at about age 16. At birth, the human infant is very dependent on others for virtually everything. Ideally the environment, represented by the upper left triangle gradually diminishes control as the individual, lower right triangle, develops the ability to take care of him/herself. This provides a progress model of an ideal developmental process.

What if the environment is insensitive or overprotective? Development would be distorted or delayed beyond the 16 year age (see figure 5). What if the environment collapsed early, making it necessary for the child to assume more responsibility than s/he is capable of handling? Development would likely be inconsistent and erratic (see figure 6).

To account for variations from the ideal in development and to provide a framework for complex dynamics in adjustment and development, the maturational control rectangle has been modified and relabeled (see figure 7).

The horizontal axis is age, from birth to death. The vertical axis represents relative free will or self-determination. There is no attempt to postulate total, mind over matter, free will; relative free will allows for limitations of environment and ability while giving room for existential choice and self-managed contingencies.

Figure 4



The Maturational Control Rectangle

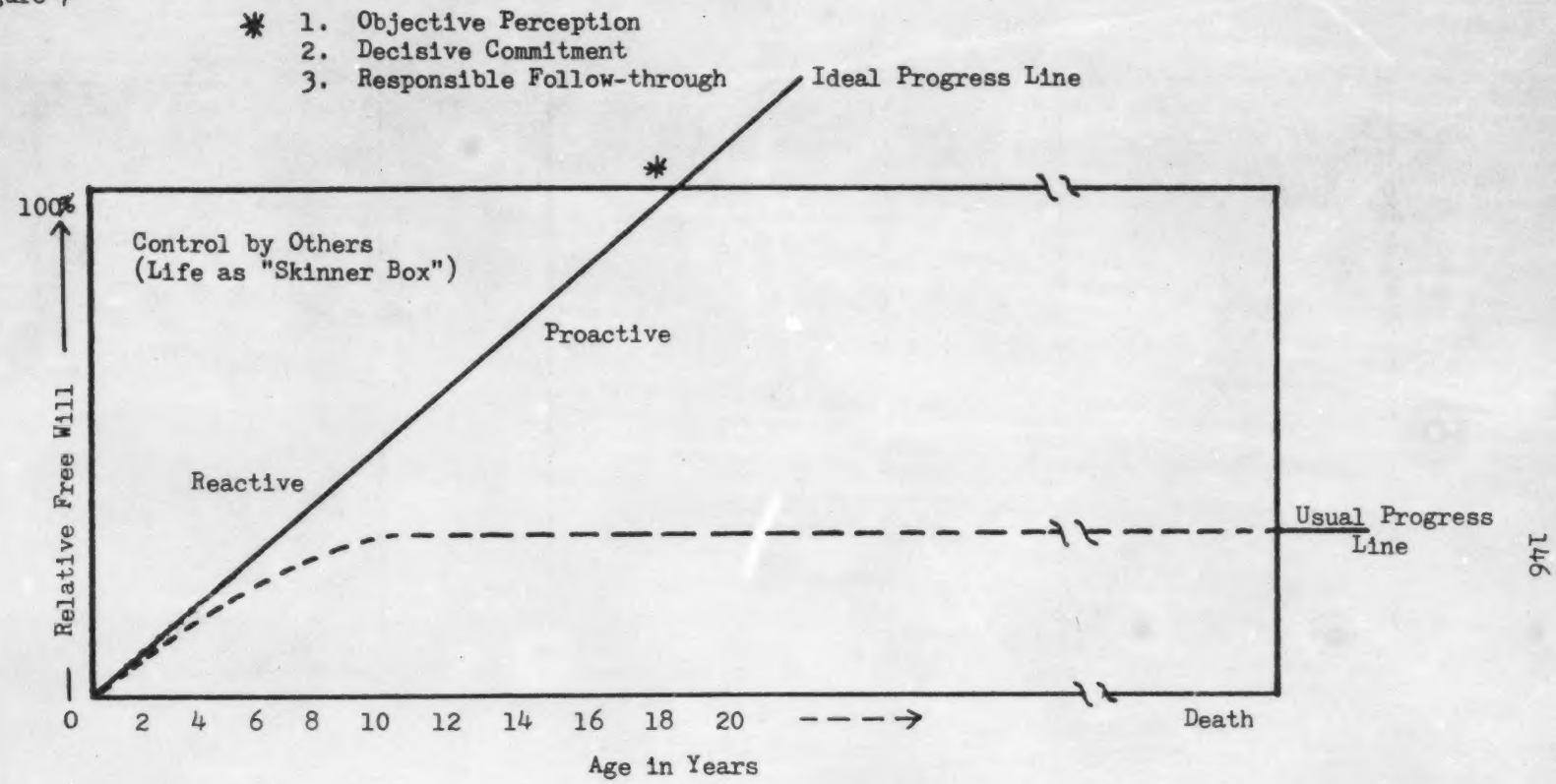
Figure 5

Result of Overprotective Environment

Figure 6

Result of Insufficient Environmental Support

Figure 7



The Responsive Therapy Model

Objective of Development The diagonal line shows ideal progress toward maturity, which is the goal of each individual. Reaching the top line, whether by way of ideal progress or a more typically erratic line, is equivalent to the self-actualization of Maslow, non-defensive living or fully functioning self of Rogers, sense of integrity of Erickson, and existence of May. It is defined operationally according to three criteria:

1. the ability to make objective perceptions of self and of the environment. This includes awareness by the individual of his desires and needs, talents and limitations, tendencies and traditions. It includes awareness that there are more than the two obvious alternatives to any problem; i.e., the preferred but impossible and the possible but unacceptable--100% successful or suicide; rather, there are many possible and acceptable solutions to virtually any problem, and the individual knows many of them.
2. the ability to make a clear, decisive commitment to pursue a preferred option from among the several which have a reasonable probability of success.
3. acceptance of responsibility for the decision and for the necessary action to assure its success. The mature person accepts the blame for failure and the credit for success with no attempt to ascribe either to circumstances or luck.

The extent to which people are limited or controlled by their environment is represented by the space to the upper left of the progress lines. All people at birth and for the first eight, plus or minus two,

years of their lives operate or behave according to the dynamics of Skinnerian behaviorism. This area can also be interpreted relative to the number or frequency of actions performed according to an operant paradigm. For this reason, the therapy of choice for all children to age 8-10 and retardates of similar mental ability is some form of behavior modification.

The dotted line represents the path of usual progress or the pattern followed by most people. While there is no available data to verify the assertion, it is claimed that upwards of 80% of the population follows this line.

Since most of the area represented in the model is above the dotted line, much behavior for most people can be explained and modified according to a behavioral system. To a certain extent, and borrowing from the learned helplessness work of Seligman (1975), whether or not people actually are externally determined, they will manifest the pattern if it fits their understanding and expectation of reality.

Life Styles There are two primary life styles. The first fits well the externally controlled, life is just a big Skinner box, perception. This is called a reactive style. Individuals emit responses according to operant or classical conditioning paradigms. This occurs quite naturally as an outgrowth or continuation of the universal requirements for early learning. As a helpless infant, and for the first eight or so years, the process of life and learning is to venture an action and test its effectiveness. Receptive learning is important, much of which fits very well the social learning model of Bandura (1969) and at early ages is very outcome oriented.

In the absence of teaching or conditioning for problem solving skills, the individual continues in a pattern of perceiving stimuli and sorting through previously learned responses for the most appropriate one. It is as if the child comes into life with a big, empty bag and commenses to fill it with behavioral responses which can be reapplied at later times. As s/he develops facility with sorting and responding, the style becomes dependable and comfortable. In the absence of teaching or reason to change, the style continues. That this is a problem will be illustrated later in the response to crisis portion.

If children, in the six to ten year range, are given experiences in the process of problem-solving or decision-making, they develop a proactive style. They are able to repeat the process of scanning for alternatives, selecting from available options, and instituting an action. This, too, is goal-directed, but follows a thought-mediated model with emphasis on simple heuristics rather than behaving as a collection of repeatable responses or products of past learning.

The wise parent or teacher will provide numerous, protected decision opportunities. By "protected" is meant the offering of several options, all of which are acceptable or at least not harmful.

The proactive-reactive difference can be stated in the verbal dichotomies of actor-reactor, agent-reagent, conformist/non-conformist-free agent. A clarification of the polarity between conformist/non-conformist and free agent may illustrate the style difference. Conformism and non-conformism, while resulting in the appearance of difference are simply valence differences of the same dynamics. A conformist does what s/he does because s/he is supposed to. A non-conformist does what s/he

does <u>because</u> s/he is not supposed to, or in reference to his/her non-conforming group, what s/he is expected to do. Only the person who is free from "supposed to" or indifferent to it can act in her/his own behalf and in a proactive sense.

<u>Maladjustment</u> Adjustment or response to crisis within this model draws heavily on the Menninger model described in <u>The Vital Balance</u> (1963). Life is perceived as a flow, carrying with it many exigencies or circumstances which require, even demand, response. Not all circumstances are negative, but even highly positive ones like special parties, weddings, etc. can exact a heavy energy toll. People do the best they can under the circumstances which they perceive. For those who have adopted a proactive, problem-solving style, adjustments result most often in socially acceptable, self-enhancing responses.

For most people, those with a reactive style, adjustment is often problematical. Visualize the child going through the early years, filling hie/her bag with responses to demands of life. Occasionally some previously-used behavior is appropriate for a new circumstance, so the child reaches down into the bag, retrieves the response, uses it, and returns it to the top of the bag.

As time passes, the child develops two things; (1) a bag of behaviors that is organized with the most frequently useful responses near the top, and successively more "expensive" and less appropriate responses going deeper until the most costly and least self-preserving response is at the bottom: (2) a practised tendency to look to the bag for responses to satisfy present demands--a reactive style.

In Menninger's system (1963), those responses near the top are called normal coping devices. They include behavior such as crying, swearing, eating, sleeping, and self-medication.

Going progressively deeper are five levels of "dyscontrol;" spelled with a "y" to designate an active state or process and not an irreversible condition. Behavior at these levels is increasingly abnormal but logical to the individual as the least extreme response necessary to preserve self. The lowest level is psychogenic death.

The dynamics of maladjustment or maladaptive behavior proceed in the following fashion:

1. A crisis occurs in the life of the individual. Crisis is defined as any circumstance which requires a response which is not near the top of a reactor's bag.
2. The individual, very much like in a stimulus generalization event, sorts deeper in his/her bag for that behavior which "worked" in the most similar prior circumstance.
3. There is a tendency to fixate on that response either until the circumstance changes or until the individual's perception can be altered.

An example of these dynamics is a teen-aged girl who witnessed the traumatic death of her father in an aircraft accident. Not having a previously-programmed response to such a catastrophe, she reached into her bag and pulled out her "big girls don't cry" and "you have to be strong for others" pattern. Two years following the accident she was unable to express any amotion; to open the gate would be to invite loss of control and total disintegration.

Another example is a person who had been taught to externalize the cause of misfortune, hence, when going through a divorce and for years after, insisted that the former spouse was mentally ill, would recover, recognize the mistake, and return to the marriage.

Therapy Since problems of maladjustment occur as a result of a reactive style and the misperception or learned limitation of sorting as the only process for resolution, and since the individual is seen as responsible for his/her state and capable of changing it in all but organically caused maladjustment, the objective of therapy is to re-educate the client.

The SITE skills are vehicles for accomplishing this special kind of teaching. They facilitate formation of a therapeutic relationship which restores some feeling of personal worth and frees up some energy for exploring circumstances.

Through the process of describing the phenomenal world, the client experiences understanding and relaxes enough to more clearly realize her/his present condition.

Proportionately more of the time in formal therapy is spent in relationship building and personal exploration because, once his/her personal perspective is more accurately focused, the client frequently is ready and capable of taking the initiative and achieving a resolution.

In a more complete therapy process, all three phases of maturity are taught; namely, clear and objective awareness of self and circumstances, analysis of and selection from among the many available options, active and responsible follow-up to assure success. Frequently the therapist will have to follow and support the client through this sequence with

several problems before the client can adopt or generalize the proactive style to future problems.

Many times the client will present multiple problems, which, in accompaniment with her/his unique style, will suggest the simultaneous or alternate use of several different specific enhancing techniques.

It may be advisable to institute some behavioral re-conditioning through operant techniques to get the client to a teachable stage. Since problems are a function of a reactive style, operant techniques will work; and, the method of choice for <u>all</u> children under eight or ten years of age and mental retardates is operant.

Parenthetically, the problem with overreliance or exclusive use of operant techniques is that they simply add a new, situation-specific behavior to the bag and, hence, do not have any long-lasting effect on the style of the client. Many clients, especially those who have a rich and variegated bag of behavior may continue on for years with little manifest maladjustment; however, those who encounter crises are not prepared to cope. It is unrealistic to believe that parents, schools, society, therapists can prepare all people for all eventualities in a reactive style.

Possibly, with clients who are older than eight or ten years of age, operant efforts at problem habits will be undertaken while some gestalt integration is being achieved, and at the same time as some Rational-emotive work is being done on some self-defeating value binds.

<u>Group Counseling</u> In many ways, the previous paragraph sets the paradigm for group counseling in that the simultaneous management of diverse procedures in one client is similar to managing different problems at the same time with two or more clients.

When the involved group is part of a system, as in marriage or family counseling, the added complexity of identifying who owns which problem and who else is reinforcing or exascerbating the problem is a major hurdle.

Once the individual group members are perceiving clearly the ownership of problems and dynamics which maintain the maladjustment, they can be taught to be more responsible for their own problems or for their share of the group problems and to be helpful in working toward resolution(s).

The goal of all therapy is to teach clients to see clearly, choose firmly, and be responsible for the outcome of their decisions.

Integration of Theories The major thrust of this book and the model described is to incorporate, in their unified and total form, all therapeutic approaches. There appears to be no need for blind or fanatic discipleship, nor for a weak, eclectic compromise. Perhaps an integration has not been accomplished in this work; perhaps one is not totally possible. It does present a potential refuge for therapists who are not comfortable with an "either-or" or "parts of both" approach to professional definition.

Summary

Responsive Therapy grew out of a professional identity crisis. Allegiance to any single therapy model was precluded by apparent worth of others; adoption of an eclectic position was seen as weaker than any theory-pure position.

The author experienced personal and professional dissonance from being trained to perform skills such as psychometric evaluations while

studying a theoretical framework (Rogers) which debunked testing. Additional confusion came from exposure to a variety of theories based on differing premises.

As an outgrowth of the dissonance, attempts were made to list acceptable truths, first from a therapeutic procedure standpoint and then dealing with philosophical foundation.

It became apparent that attempts to sort out "Truth," in actuality, contributed error by altering the philosophical context which gave validity to theory. The dilemma was resolved by incorporating all models without alteration.

Several assumptions about people are necessary premises for understanding Responsive Therapy. These are:

1. People are basically good. Good people can and occasionally do behave badly.
2. Individuals have the opportunity for choice; i.e., relative free will. They do not often realize or use that opportunity.
3. Maturity consists of the ability to
   a. obtain objective perceptions of self and of reality.
   b. make clear, decisive commitments.
   c. demonstrate self-responsibility for choices.
4. Negative forces, evil, sin are conditions, occurrances, or behavior which restrict attainment and practice of self-knowledge, self-choice, and self-responsibility.
5. Most personal problems are self-induced and are self-defeating. They arise from clouded perception, improper conditioning, or irresponsibility, and result in poor (i.e., stupid) choices.

6. The physical, social, and emotional "worlds" operate lawfully, hence predictably. Free choice requires knowledge of the limitations set by law.
7. People make the best adjustment possible within their perceptual set (ala Menninger, 1963); therefore, therapy for mal-adaptive adjustment is a form of education for more accurate, objective perceptions of reality (ala Seligman, 1975), for more numerous potential alternatives, or for skills in managing the process of self-responsibility.

Similarly, there are premises which underly use of theory itself, and, hence, are important bases for understanding Responsive Therapy.

1. Existing theories are reports based on empirical, behavioral referents; therefore, all contain some "truth" as a model or construct of how things really are.
2. Differences among theories are a result of
   a. sampling error. Not all theorists view the same subjects under the same conditions, yet most theorists generalize quite freely to all people.
   b. the model used to explain the observations. While the empirical referents might be described clearly, the explanations of dynamics and relations are subject to all of the frailties of communication.
   c. successive observations being colored or distorted as a result of early formulations of the model; i.e., perceptual bias and selectivity.

3. Life cannot be described by either pole of a dichotomy (e.g., objective-subjective, behavioristic-gestalt, etc.) nor can it be explained by one dichotomy and a continuum between extremes; however, to the extent that each model represents truth, it must be included in a more complex description of reality.
4. Models representing growth, development, and learning have one commonality; they explain progress. Models of adjustment, mental health, mental illness, physical health, and physical illness describe facilitative and inhibitive qualities or conditions which affect that progress.

The Responsive Therapy model includes a framework for development of the individual from birth to maturity, ideally taking about 18 years. Maturity is defined as the ability to have clear and objective perceptions of self and environment, make decisive commitments from available alternatives, and demonstrate responsibility for decisions by appropriate behavior.

Two life styles are described, that of a reactive type which consists of stimulus-cued response sets, and that of a proactive type which is process oriented.

Maladjustment occurs when reactors have no effective response in their repertoire. They emit the best response they have, which is maladaptive but preserves the self.

Therapy consists of teaching proactive techniques to reactors; i.e., clarifying the broadening perceptions, analyzing and selecting from among alternatives, and responsibly making the chosen option a successful one.

With the added problem of interpersonal dynamics and problem ownership, group counseling operates according to the same dynamics.

Responsive Therapy is seen as a viable position for therapists who cannot be comfortable with either a single approach or eclecticism.

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